

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2621

## CERTIFICATE OF DEATH

02606

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>2 HRS.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>310 PIEDMONT AVE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>MARY</b> Last <b>ABRAMS</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>10</b> Year <b>1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 14 1899</b>	
9. AGE (In years last birthday) <b>59</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>EVERETT BARHAM</b>				14. MOTHER'S MAIDEN NAME <b>VIOLA ALLEN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>213-22-4561</b>		17. INFORMANT <b>Wesley Abrams, 310 Piedmont Ave. Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> <b>490x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Lobar Pneumonia, right</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cumberland, Md.</b>				20g. (County) <b>Cumberland</b>			
20h. (State) <b>Md.</b>							
21. I certify that I attended the deceased from <b>3/8</b> 19 <b>58</b> , to <b>3/10</b> 19 <b>58</b> , that I last saw the deceased alive on <b>3/10</b> 19 <b>58</b> , and that death occurred at <b>1:45 P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>3/11/58</b>							
ACTUAL SIGNATURE <b>Leo J. Ley Jr.</b>				M.D. <b>Leo J. Ley Jr.</b>			
PHYSICIAN'S NAME (Type) <b>LEO LEY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 13, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George, Cumberland, Md.</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 14 '58</b>	
						24b. REGISTRAR'S SIGNATURE <b>Alfred Lewis</b>	

RECEIVED

MAR 14 1958

BUREAU V. 31

HOSPITAL OR  
may be retained  
TO FUNERAL DIRE  
page 3 should b  
the registrar prior

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours c  
he hospital or attending physician.  
R: After this certificate has been signed by the attending physician and completely filled in by th  
neral director,  
attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with  
to burial, cremation, or removal, and in any event within 24 hours after death.

both: Page 4

15 (4)  
1/57

Item 8, Film G227, 4/7/58 fcy

2622

CERTIFICATE OF DEATH

Reg. Dist. No.

02607

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN lb <b>53 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				d. STREET ADDRESS <b>320 CUMBERLAND ST</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ELIZABETH ADAMS</b>				4. DATE OF DEATH Month Day Year <b>MARCH 30 1958</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 24 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM WITHERS</b>				14. MOTHER'S MAIDEN NAME <b>FANNIE C. WELDON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Harry Withers Jacksonville, Fla.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Vascular Dis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>Suppurations of aqk</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Since 2.26.58</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>Carcinoma Rt. breast Mastectomy</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-5-1958</b> to <b>3.30.1958</b> , that I last saw the deceased alive on <b>3.29.1958</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. F. WILLIAMS</b>		M.D. <b>Cumberland, Md.</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b>		DATE SIGNED <b>3/31/58</b>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 2 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Rebecca</b>			

MEDICAL CERTIFICATION

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 8

APR 2 1958

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02608

2689

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Barton</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>J.</b> Last <b>Ayers</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1885</b>
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.	IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ex-coal miner &amp; merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Barton, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Ayers</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Penaman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Miners Hospital records</b>	
17. INFORMANT <b>Miners Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> DUE TO <b>Cardio-vascular-renal disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardio-vascular-renal disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>sudden over 6 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of right humerous</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped on ice near home, fell &amp; fractured right</b>	
20c. TIME OF INJURY Month, Day, Year <b>10</b> Hour <b>p. m.</b> <b>Feb. 20, 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <b>Highway, home</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Barton</b>		20f. (City or town) (County) (State) <b>Allegany Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		DATE SIGNED <b>March 6-1958</b>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Moscow Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Es. Boul-westernport, Md</b>		24a. REC'D BY REGISTRAR <b>MAR 10 58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Deming</b>			

RECEIVED

MAR 10 1958

BUREAU V. 2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2623

## CERTIFICATE OF DEATH

02609

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2HRS. 40 MINS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>108 GRAND AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>CAROLINE</b> Middle <b>BATIE</b> Last <b>BATIE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 4, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. FATHER'S NAME <b>GEORGE GITTINGS</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH HARRIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> DUE TO <b>Acute Congestion Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO <b>yes.</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis &amp; Fatigue Undeveloped</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept</b> , 1954, to <b>March</b> , 1958, that I last saw the deceased alive on <b>March 5</b> , 1958, and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. GOVERTON HIMMELWRIGHT</b>		DATE SIGNED <b>3/7/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. GOVERTON HIMMELWRIGHT</b>		ADDRESS (Street, city or town, state) <b>133 W. Carey, Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 8, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Paul Smith</b>			

RECEIVED

MAR 11 1963

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF BIRTH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF PHYSICIAN: [illegible]  
SIGNATURE OF REGISTRAR: [illegible]  
DATE OF REGISTRATION: [illegible]

FOR STATE  
HEALTH DEPT.

2690

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>X</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Nikep,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>M.</b> Last <b>Beeman</b>			4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 58</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 22-1869</b>		9. AGE (In years last birthday) <b>89</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Nikep, Md.</b>	
13. FATHER'S NAME <b>Samuel Miller</b>			14. MOTHER'S MAIDEN NAME <b>Charlotte Miller</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>(Margaret Hotchkiss, Lonaconing, Md.)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Fractured skull (frontal) also left humerous</b> (c) <b>A fall</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <b>*</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter cause of injury in Part I or Part II) <b>side of forehead &amp; humerous on concrete</b> <b>Walking down porch steps, became weak, fell striking left</b>			
20c. TIME OF INJURY Month, Day, Year <b>10-45-2-3-29 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>In front of home-Nikep</b>	
				20f. (City or town) (County) (State) <b>Allegany Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
				DEPUTY MEDICAL EXAMINER <b>March 31-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Moscow, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>			ADDRESS <b>Lonaconing, Md.</b>		
24a. REC'D BY REGISTRAR <b>APR 3 '58</b>			24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

APR 7 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. **02610**

2624

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>12 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LENA</b> Middle <b>M.</b> Last <b>BENDER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>8</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>APRIL 20, 1888</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>W.VA., Martinsburg</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13. FATHER'S NAME <b>MARTIN M. BROWN</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH BROWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>Edgar H. Bender,</b>				18. ADDRESS <b>528 Schlund Avenue Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diverticulitis sigmoid colon</b> <b>572.1</b> DUE TO <b>with suppurative peritonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>subdiaphragm</b> DUE TO (c) <b>Myocardial failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Cumberland</b>				20g. (County) <b>Allegany</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Feb 24</b> , 19 <b>58</b> , to <b>Mar 8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 7</b> , 19 <b>58</b> , and that death occurred at <b>7:30 A.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland Md</b> DATE SIGNED <b>Mar 8 '58</b>							
ACTUAL SIGNATURE <b>W. M. Fafer Jr.</b>				M.D. <b>Cumberland Md</b>			
PHYSICIAN'S NAME (Type) <b>W. M. Fafer Jr.</b>				5 Washington St. Cumberland Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Allegany</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

RECEIVED  
MAR 11 1953  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2625

## CERTIFICATE OF DEATH

02611

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>929 Maryland Avenue</b>		d. STREET ADDRESS <b>929 Maryland Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AGNES</b> Middle <b>MABEL</b> Last <b>BENNETT</b>		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 6, 1900</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Tunnelton, West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Abel M. Conner</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Shaver</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Otis Lee Bennett</b>	
17. INFORMANT <b>926 Maryland Avenue</b> <b>Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Occlusion</b> DUE TO Coronary Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 da.</b> <b>6 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 31, 1957</b> to <b>March 17, 1958</b> , that I last saw the deceased alive on <b>March 17, 1958</b> , and that death occurred at <b>9.20P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Hallinan M.D.</b>		ADDRESS (Street, city or town, state) <b>140 Bedford St.</b> DATE SIGNED <b>March 19, 1958</b>	
PHYSICIAN'S NAME (Type) <b>James P. Hallinan M. D.</b>		<b>Cumberland, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REG'D BY REGISTRAR <b>MAR 20 1958</b> 24b. REGISTRAR'S SIGNATURE <b>W. F. Fisher</b>	

CERTIFICATE OF DEATH

ARKANSAS STATE DEPARTMENT OF HEALTH - BATHING - 18

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 2:01 PM		6. PLACE OF DEATH Memphis, Tennessee	
7. CAUSE OF DEATH Suicide		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Sikeston, Missouri	
10. OCCUPATION Attorney		11. EDUCATION High School		12. MARITAL STATUS Single	
13. PREVIOUS ILLNESS None		14. PREVIOUS SURGERY None		15. PREVIOUS TRAUMA None	
16. PREVIOUS DRUGS None		17. PREVIOUS ALCOHOL None		18. PREVIOUS TOBACCO None	
19. PREVIOUS OTHER None		20. PREVIOUS OTHER None		21. PREVIOUS OTHER None	
22. PREVIOUS OTHER None		23. PREVIOUS OTHER None		24. PREVIOUS OTHER None	
25. PREVIOUS OTHER None		26. PREVIOUS OTHER None		27. PREVIOUS OTHER None	
28. PREVIOUS OTHER None		29. PREVIOUS OTHER None		30. PREVIOUS OTHER None	
31. PREVIOUS OTHER None		32. PREVIOUS OTHER None		33. PREVIOUS OTHER None	
34. PREVIOUS OTHER None		35. PREVIOUS OTHER None		36. PREVIOUS OTHER None	
37. PREVIOUS OTHER None		38. PREVIOUS OTHER None		39. PREVIOUS OTHER None	
40. PREVIOUS OTHER None		41. PREVIOUS OTHER None		42. PREVIOUS OTHER None	
43. PREVIOUS OTHER None		44. PREVIOUS OTHER None		45. PREVIOUS OTHER None	
46. PREVIOUS OTHER None		47. PREVIOUS OTHER None		48. PREVIOUS OTHER None	
49. PREVIOUS OTHER None		50. PREVIOUS OTHER None		51. PREVIOUS OTHER None	
52. PREVIOUS OTHER None		53. PREVIOUS OTHER None		54. PREVIOUS OTHER None	
55. PREVIOUS OTHER None		56. PREVIOUS OTHER None		57. PREVIOUS OTHER None	
58. PREVIOUS OTHER None		59. PREVIOUS OTHER None		60. PREVIOUS OTHER None	
61. PREVIOUS OTHER None		62. PREVIOUS OTHER None		63. PREVIOUS OTHER None	
64. PREVIOUS OTHER None		65. PREVIOUS OTHER None		66. PREVIOUS OTHER None	
67. PREVIOUS OTHER None		68. PREVIOUS OTHER None		69. PREVIOUS OTHER None	
70. PREVIOUS OTHER None		71. PREVIOUS OTHER None		72. PREVIOUS OTHER None	
73. PREVIOUS OTHER None		74. PREVIOUS OTHER None		75. PREVIOUS OTHER None	
76. PREVIOUS OTHER None		77. PREVIOUS OTHER None		78. PREVIOUS OTHER None	
79. PREVIOUS OTHER None		80. PREVIOUS OTHER None		81. PREVIOUS OTHER None	
82. PREVIOUS OTHER None		83. PREVIOUS OTHER None		84. PREVIOUS OTHER None	
85. PREVIOUS OTHER None		86. PREVIOUS OTHER None		87. PREVIOUS OTHER None	
88. PREVIOUS OTHER None		89. PREVIOUS OTHER None		90. PREVIOUS OTHER None	
91. PREVIOUS OTHER None		92. PREVIOUS OTHER None		93. PREVIOUS OTHER None	
94. PREVIOUS OTHER None		95. PREVIOUS OTHER None		96. PREVIOUS OTHER None	
97. PREVIOUS OTHER None		98. PREVIOUS OTHER None		99. PREVIOUS OTHER None	
100. PREVIOUS OTHER None		101. PREVIOUS OTHER None		102. PREVIOUS OTHER None	

BUREAU X. 4

MAR 26 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2626

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland Maryland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>526 Beall Street</b>				d. STREET ADDRESS <b>472 Baltimore Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertha</b> Middle <b>Ann</b> Last <b>Bennett</b>				4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 27, 1883</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Artemas, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jonathan Potts</b>				14. MOTHER'S MAIDEN NAME <b>Amanda Purcell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Woodrow Bennett Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>171x Carcinoma, cervix</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 19, 1958</b> , to <b>March 6, 1958</b> , that I last saw the deceased alive on <b>March 6, 1958</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>3/8/58</b>							
ACTUAL SIGNATURE <b>Leo J. Ley, Jr.</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Leo J. Ley Jr M.D.</b>				<b>456 N. Centre St. Cumberland, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fairview Christian Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Bedford County, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESSES		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF CLERGY	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF DISTRICT ATTORNEY		20. SIGNATURE OF SHERIFF		21. SIGNATURE OF CLERK	
22. SIGNATURE OF CHIEF OF POLICE		23. SIGNATURE OF DEPUTY CHIEF OF POLICE		24. SIGNATURE OF INSPECTOR	
25. SIGNATURE OF DETECTIVE		26. SIGNATURE OF OFFICER		27. SIGNATURE OF SGT.	
28. SIGNATURE OF CAPTAIN		29. SIGNATURE OF MAJOR		30. SIGNATURE OF LIEUTENANT	
31. SIGNATURE OF SERGEANT		32. SIGNATURE OF PRIVATE		33. SIGNATURE OF CORP.	
34. SIGNATURE OF PVT.		35. SIGNATURE OF PFC.		36. SIGNATURE OF PFC.	
37. SIGNATURE OF PFC.		38. SIGNATURE OF PFC.		39. SIGNATURE OF PFC.	
40. SIGNATURE OF PFC.		41. SIGNATURE OF PFC.		42. SIGNATURE OF PFC.	
43. SIGNATURE OF PFC.		44. SIGNATURE OF PFC.		45. SIGNATURE OF PFC.	
46. SIGNATURE OF PFC.		47. SIGNATURE OF PFC.		48. SIGNATURE OF PFC.	
49. SIGNATURE OF PFC.		50. SIGNATURE OF PFC.		51. SIGNATURE OF PFC.	
52. SIGNATURE OF PFC.		53. SIGNATURE OF PFC.		54. SIGNATURE OF PFC.	
55. SIGNATURE OF PFC.		56. SIGNATURE OF PFC.		57. SIGNATURE OF PFC.	
58. SIGNATURE OF PFC.		59. SIGNATURE OF PFC.		60. SIGNATURE OF PFC.	
61. SIGNATURE OF PFC.		62. SIGNATURE OF PFC.		63. SIGNATURE OF PFC.	
64. SIGNATURE OF PFC.		65. SIGNATURE OF PFC.		66. SIGNATURE OF PFC.	
67. SIGNATURE OF PFC.		68. SIGNATURE OF PFC.		69. SIGNATURE OF PFC.	
70. SIGNATURE OF PFC.		71. SIGNATURE OF PFC.		72. SIGNATURE OF PFC.	
73. SIGNATURE OF PFC.		74. SIGNATURE OF PFC.		75. SIGNATURE OF PFC.	
76. SIGNATURE OF PFC.		77. SIGNATURE OF PFC.		78. SIGNATURE OF PFC.	
79. SIGNATURE OF PFC.		80. SIGNATURE OF PFC.		81. SIGNATURE OF PFC.	
82. SIGNATURE OF PFC.		83. SIGNATURE OF PFC.		84. SIGNATURE OF PFC.	
85. SIGNATURE OF PFC.		86. SIGNATURE OF PFC.		87. SIGNATURE OF PFC.	
88. SIGNATURE OF PFC.		89. SIGNATURE OF PFC.		90. SIGNATURE OF PFC.	
91. SIGNATURE OF PFC.		92. SIGNATURE OF PFC.		93. SIGNATURE OF PFC.	
94. SIGNATURE OF PFC.		95. SIGNATURE OF PFC.		96. SIGNATURE OF PFC.	
97. SIGNATURE OF PFC.		98. SIGNATURE OF PFC.		99. SIGNATURE OF PFC.	
100. SIGNATURE OF PFC.		101. SIGNATURE OF PFC.		102. SIGNATURE OF PFC.	

BUREAU V. 8

MAR 11 1938

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2627

## CERTIFICATE OF DEATH

02613

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b> c. LENGTH OF STAY IN 1b <b>11 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND 02</b> d. STREET ADDRESS <b>39 LAMONT STREET</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CLARA</b> Middle <b>E.</b> Last <b>BUTLER</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>8,</b> Year <b>1958</b>							
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>OCTOBER 12</b>		9. AGE (In years just birthday) yrs. <b>55</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. AMERICA</b>	
13. FATHER'S NAME <b>GEORGE BUTLER</b>						14. MOTHER'S MAIDEN NAME <b>SHOWACRE, LAURA</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Myeloma</b> <b>260x</b> DUE TO <b>Diabetic Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>1/27/58</b> , 19____, to <b>3/8/58</b> , 19____, that I last saw the deceased alive on <b>3/1/58</b> , 19____, and that death occurred at <b>6:35 P. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>3/9/58</b> ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) <b>DR. RICHARD J. WILLIAMS</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 11 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 12 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al Lewis</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. 8

MAR 12 1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02614

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>McCoole</i>		c. LENGTH OF STAY IN 1b <i>X</i> <i>McCoole</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Route 3 Keyser</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Alva</i> Middle <i>Olen</i> Last <i>Butts</i>		4. DATE OF DEATH Month <i>March</i> Day <i>18</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>13 May 1907</i>
9. AGE (In years last birthday) <i>50</i> yrs.		IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carman Helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baltimore Ohio R.R. Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U. S. A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James D. Butts</i>		14. MOTHER'S MAIDEN NAME <i>Flora Murphy</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>236 14 4950</i>	
17. INFORMANT <i>Geneive Butts</i>		Address <i>McCoole, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Exsanguination</i> DUE TO <i>976X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>due to a gunshot wound right side of</i> (c) <i>face and neck self inflicted</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Dependent</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Shot himself with a .38 cal. rifle</i>	
20c. TIME OF INJURY Hour <i>9:45</i> a. m. <i>3-18</i> 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>McCoole ALLEGANY Md.</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Demming</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. V. Demming</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <i>March 18-1958</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>24 Mar. 58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Queens Point</i>	22d. LOCATION (City, town, or county) (State) <i>Keyser, W. Va.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Allen M. Rottach</i>		ADDRESS <i>Keyser, W. Va.</i>	
24a. REC'D BY REGISTRAR DATE <i>MAR 26 1958</i>		24b. REGISTRAR'S SIGNATURE <i>W. H. Smith</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
REGISTER

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. BURNETT		45		M		W		MAR 27 1958		BALTIMORE, MARYLAND	
RESIDENT OF		OCCUPATION		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		CAUSE OF DEATH	
1234 E. BALTIMORE ST.		Carpenter		High School		Married		None		Heart Disease	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY		DATE OF ENTRY INTO STATE		DATE OF ENTRY INTO COUNTRY	
JAN 15 1913		BALTIMORE, MARYLAND		JAN 15 1913		JAN 15 1913		JAN 15 1913		JAN 15 1913	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
MAR 27 1958		BALTIMORE, MARYLAND		MAR 27 1958		BALTIMORE, MARYLAND		MAR 27 1958		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
MAR 27 1958		BALTIMORE, MARYLAND		MAR 27 1958		BALTIMORE, MARYLAND		MAR 27 1958		BALTIMORE, MARYLAND	

BURNETT J. H.

MAR 27 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2691

CERTIFICATE OF DEATH

03063

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Vale Summit, Box 358</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				d. STREET ADDRESS <u>R. D. No 1 Frostburg, Md.</u>			
3. NAME OF DECEASED (Type or print) First <u>Mary Ellen</u> Middle <u>Chabot</u> Last <u></u>				4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 15 1936</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Vale Summit</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Cain</u>				14. MOTHER'S MAIDEN NAME <u>Mary Doyle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Francis Chabot, 3914 Bruce St. Alexandria Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>9 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAR 31, 1958</u> , to <u>MAR 31, 1958</u> , that I last saw the deceased alive on <u>MAR 31, 1958</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm Lane</u> M.D.				ADDRESS (Street, city or town, state) <u>Frostburg Md</u>		DATE SIGNED <u>4-2-58</u>	
PHYSICIAN'S NAME (Type) <u>Wm Lane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-3-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's Cemetery Frostburg Md.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. H. Mutterly</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Leach</u>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

BUREAU V. 2

APR 7 1958

RECEIVED

1. NAME OF DECEASED  JAMES EARL RAY		2. PLACE OF BIRTH  MOBILE, ALABAMA	
3. SEX  MALE		4. RACE  WHITE	
5. DATE OF BIRTH  JANUARY 5, 1928		6. DATE OF DEATH  APRIL 4, 1968	
7. TIME OF DEATH  2:01 PM		8. PLACE OF DEATH  MEMPHIS, TENNESSEE	
9. CAUSE OF DEATH  HEART DISEASE		10. MANNER OF DEATH  NATURAL	
11. SIGNATURE OF PHYSICIAN  J. H. HARRIS		12. SIGNATURE OF REGISTRAR  J. H. HARRIS	
13. SIGNATURE OF DECEASED  JAMES EARL RAY		14. SIGNATURE OF WITNESSES  JAMES EARL RAY	
15. SIGNATURE OF DECEASED  JAMES EARL RAY		16. SIGNATURE OF DECEASED  JAMES EARL RAY	
17. SIGNATURE OF DECEASED  JAMES EARL RAY		18. SIGNATURE OF DECEASED  JAMES EARL RAY	
19. SIGNATURE OF DECEASED  JAMES EARL RAY		20. SIGNATURE OF DECEASED  JAMES EARL RAY	
21. SIGNATURE OF DECEASED  JAMES EARL RAY		22. SIGNATURE OF DECEASED  JAMES EARL RAY	
23. SIGNATURE OF DECEASED  JAMES EARL RAY		24. SIGNATURE OF DECEASED  JAMES EARL RAY	
25. SIGNATURE OF DECEASED  JAMES EARL RAY		26. SIGNATURE OF DECEASED  JAMES EARL RAY	
27. SIGNATURE OF DECEASED  JAMES EARL RAY		28. SIGNATURE OF DECEASED  JAMES EARL RAY	
29. SIGNATURE OF DECEASED  JAMES EARL RAY		30. SIGNATURE OF DECEASED  JAMES EARL RAY	
31. SIGNATURE OF DECEASED  JAMES EARL RAY		32. SIGNATURE OF DECEASED  JAMES EARL RAY	
33. SIGNATURE OF DECEASED  JAMES EARL RAY		34. SIGNATURE OF DECEASED  JAMES EARL RAY	
35. SIGNATURE OF DECEASED  JAMES EARL RAY		36. SIGNATURE OF DECEASED  JAMES EARL RAY	
37. SIGNATURE OF DECEASED  JAMES EARL RAY		38. SIGNATURE OF DECEASED  JAMES EARL RAY	
39. SIGNATURE OF DECEASED  JAMES EARL RAY		40. SIGNATURE OF DECEASED  JAMES EARL RAY	
41. SIGNATURE OF DECEASED  JAMES EARL RAY		42. SIGNATURE OF DECEASED  JAMES EARL RAY	
43. SIGNATURE OF DECEASED  JAMES EARL RAY		44. SIGNATURE OF DECEASED  JAMES EARL RAY	
45. SIGNATURE OF DECEASED  JAMES EARL RAY		46. SIGNATURE OF DECEASED  JAMES EARL RAY	
47. SIGNATURE OF DECEASED  JAMES EARL RAY		48. SIGNATURE OF DECEASED  JAMES EARL RAY	
49. SIGNATURE OF DECEASED  JAMES EARL RAY		50. SIGNATURE OF DECEASED  JAMES EARL RAY	
51. SIGNATURE OF DECEASED  JAMES EARL RAY		52. SIGNATURE OF DECEASED  JAMES EARL RAY	
53. SIGNATURE OF DECEASED  JAMES EARL RAY		54. SIGNATURE OF DECEASED  JAMES EARL RAY	
55. SIGNATURE OF DECEASED  JAMES EARL RAY		56. SIGNATURE OF DECEASED  JAMES EARL RAY	
57. SIGNATURE OF DECEASED  JAMES EARL RAY		58. SIGNATURE OF DECEASED  JAMES EARL RAY	
59. SIGNATURE OF DECEASED  JAMES EARL RAY		60. SIGNATURE OF DECEASED  JAMES EARL RAY	
61. SIGNATURE OF DECEASED  JAMES EARL RAY		62. SIGNATURE OF DECEASED  JAMES EARL RAY	
63. SIGNATURE OF DECEASED  JAMES EARL RAY		64. SIGNATURE OF DECEASED  JAMES EARL RAY	
65. SIGNATURE OF DECEASED  JAMES EARL RAY		66. SIGNATURE OF DECEASED  JAMES EARL RAY	
67. SIGNATURE OF DECEASED  JAMES EARL RAY		68. SIGNATURE OF DECEASED  JAMES EARL RAY	
69. SIGNATURE OF DECEASED  JAMES EARL RAY		70. SIGNATURE OF DECEASED  JAMES EARL RAY	
71. SIGNATURE OF DECEASED  JAMES EARL RAY		72. SIGNATURE OF DECEASED  JAMES EARL RAY	
73. SIGNATURE OF DECEASED  JAMES EARL RAY		74. SIGNATURE OF DECEASED  JAMES EARL RAY	
75. SIGNATURE OF DECEASED  JAMES EARL RAY		76. SIGNATURE OF DECEASED  JAMES EARL RAY	
77. SIGNATURE OF DECEASED  JAMES EARL RAY		78. SIGNATURE OF DECEASED  JAMES EARL RAY	
79. SIGNATURE OF DECEASED  JAMES EARL RAY		80. SIGNATURE OF DECEASED  JAMES EARL RAY	
81. SIGNATURE OF DECEASED  JAMES EARL RAY		82. SIGNATURE OF DECEASED  JAMES EARL RAY	
83. SIGNATURE OF DECEASED  JAMES EARL RAY		84. SIGNATURE OF DECEASED  JAMES EARL RAY	
85. SIGNATURE OF DECEASED  JAMES EARL RAY		86. SIGNATURE OF DECEASED  JAMES EARL RAY	
87. SIGNATURE OF DECEASED  JAMES EARL RAY		88. SIGNATURE OF DECEASED  JAMES EARL RAY	
89. SIGNATURE OF DECEASED  JAMES EARL RAY		90. SIGNATURE OF DECEASED  JAMES EARL RAY	
91. SIGNATURE OF DECEASED  JAMES EARL RAY		92. SIGNATURE OF DECEASED  JAMES EARL RAY	
93. SIGNATURE OF DECEASED  JAMES EARL RAY		94. SIGNATURE OF DECEASED  JAMES EARL RAY	
95. SIGNATURE OF DECEASED  JAMES EARL RAY		96. SIGNATURE OF DECEASED  JAMES EARL RAY	
97. SIGNATURE OF DECEASED  JAMES EARL RAY		98. SIGNATURE OF DECEASED  JAMES EARL RAY	
99. SIGNATURE OF DECEASED  JAMES EARL RAY		100. SIGNATURE OF DECEASED  JAMES EARL RAY	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02615

Reg. Dist. No.

2628

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>HAMPSHIRE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND, MD.</b>		c. LENGTH OF STAY IN lb <b>38 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>ROMNEY</b> <b>85 x -3</b> <input checked="" type="checkbox"/> <b>IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle <b>M.</b> Last <b>DAVIS</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>27</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPTEMBER 14 1888</b>
9. AGE (In years last birthday) <b>68 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOSEPH TIMBROOK</b>		14. MOTHER'S MAIDEN NAME <b>MELINDA PYLES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE.</b> <b>4500</b> DUE TO <b>ARTERIOSCLEROTIC VASCULAR DISEASE.</b> <b>IMPACTED FRACTURE LEFT FEMUR AT SURGICAL NECK</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>IMPACTED FRACTURE LEFT FEMUR AT SURGICAL NECK</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>IMPACTED FRACTURE LEFT FEMUR AT SURGICAL NECK</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>903.0</b>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SITTING IN CHAIR, WENT TO STAND UP AND FELL TO THE FLOOR</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>LL: 8:30</b> <b>Feb. 16, 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>		20f. (City or town) <b>ROMNEY, HAMPSHIRE</b> (State) <b>W. VA.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H. V. Deming MD</b>		DATE SIGNED <b>3/27/58</b>	
EXAMINER'S NAME (Type) <b>H. V. DEMING, MD</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>3-30-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Romney, Hamp. Co., W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. E. Coughlin</b> ADDRESS <b>Cumbr. Funeral Home Romney W. Va.</b>		24a. REC'D BY REGISTRAR <b>Alb. Leach</b> 24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>	
DATE <b>MAR 31 '58</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 31 1959

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02616

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

2711

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Old Town</b>	c. LENGTH OF STAY IN 1b <b>59 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Old Town Md.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Oldtown Md.</b>		d. STREET ADDRESS <b>Oldtown Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Dewey</b> Last <b>Deffinbaugh</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 23-1899</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.	IF UNDER 24 HRS. Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian-Old Town High School</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Old Town, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elwood Deffinbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Keziah Wagner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-24-1939</b>	
17. INFORMANT <b>(wife) Corinne S. Deffinbaugh, Old Town, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 21-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>3/24/1958</b>	<b>Oldtown Cem.</b>	<b>Oldtown Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>		ADDRESS <b>Cumb. Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 26 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Deauch</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 26 1953

BUREAU V. 8

STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 1,9 FilmG227 3-31-58 et  
2629  
CERTIFICATE OF DEATH

Reg. Dist. No.

02617

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Allegany, W. Va.</b>		c. LENGTH OF STAY IN 1b <b>15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cumberland - New Creek W. Va.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hosp. (Cumberland)</b>			d. STREET ADDRESS <b>New Creek, W. Va.</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Del Signore</b> <b>John</b>			4. DATE OF DEATH <b>3-19-58</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-24-91</b>	9. AGE (In years last birthday) <b>77 3/4 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
13. FATHER'S NAME <b>Frank DelSignore</b>			14. MOTHER'S MAIDEN NAME <b>Lucy DelSignore</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Pt. chart</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Cardiac failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary sclerosis</b> DUE TO (c) <b>mal nutrition</b>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>3-4-</b> , 19 <b>58</b> , to <b>3-19-</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-19-58</b> , 19 <b>58</b> , and that death occurred at <b>8:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED <b>Earl R. Paul</b>					
ACTUAL SIGNATURE <b>Earl R. Paul</b> M.D. <b>Cumberland, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>Earl R. Paul</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-22-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sts. Peter and Paul Cem.</b>	
22d. LOCATION (City, town, or county)		(State) <b>Cumberland, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hagers Funeral Home</b>			24a. REC'D BY REGISTRAR <b>W. J. Search</b>		
ADDRESS <b>Hagers Funeral Home</b>			24b. REGISTRAR'S SIGNATURE <b>W. J. Search</b>		
DATE <b>MAR 26 1958</b>			DATE <b>MAR 26 1958</b>		

BUREAU V. S.

MAR 27 1953

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>93 American Ave.</b>		d. STREET ADDRESS <b>93 American Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>(FILER)</b> Last <b>DENSMORE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>23</b> , Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 7, 1879</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William A. Filer</b>		14. MOTHER'S MAIDEN NAME <b>Frances Prichard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>	
17. INFORMANT <b>Mrs. Earl Brain, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>592x</b> IMMEDIATE CAUSE (a) <b>Hypertension</b> DUE TO (b) <b>Chr. nephritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 19, 1958</b> , to <b>March 22, 1958</b> , that I last saw the deceased alive on <b>March 22, 1958</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. O. McLane</b>		ADDRESS (Street, city or town, state) <b>E. Main St., Frostburg, Md.</b>	
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>		DATE SIGNED <b>Mar 23 1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 26, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst,</b>		ADDRESS <b>Frostburg, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

ADDITIONAL  
PAGE CONTENT

WILLIAM B. ROSS

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

BUREAU X 11

MAR 26 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02619

2630

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Allegheny</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>707 Hilltop Drive</u>		d. STREET ADDRESS <u>707 Hilltop Drive</u>	
3. NAME OF DECEASED (Type or print) <u>George Emory Deremer</u>		4. DATE OF DEATH <u>Mar 30 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 3, 1877</u>
9. AGE (In years lost birthday) <u>80 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>Retired Coal Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fort Hill Hi School</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry Deremer</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Blair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Donald Unstot - 707 Hilltop Drive</u>	
17. INFORMANT <u>Donald Unstot - 707 Hilltop Drive</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO <u>Hypertensive Arterio Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Basal ganglia</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10:21</u> , 19 <u>57</u> , to <u>3:30</u> , 19 <u>58</u> , that I lost saw the deceased olive on <u>3:28</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. J. Williams</u>		DATE SIGNED <u>3/31/58</u>	
PHYSICIAN'S NAME (Type) <u>R. J. Williams</u>		M.D. <u>Cumberland, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr 1, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hofer</u>		ADDRESS <u>Cumberland Md</u>	
24. REC'D BY REGISTRAR <u>APR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Overland</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

BUREAU V

APR 3 1958

RECEIVED

FOR STATE  
HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2631 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02620

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M d.</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				/ d. STREET ADDRESS <u>38 Grand Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alva</u> Middle <u>H.</u> Last <u>Duckworth</u>				4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5-1907</u>		9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant-Victor Cullen State Hospital</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>Old Town, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>
13. FATHER'S NAME <u>John Thomas Duckworth</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Haugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>W. W. 2</u>		17. INFORMANT <u>Memorial Hospital records.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia(bilateral)</u> about <u>4</u> days <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause lost. DUE TO (c) <u>  </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. V. Deming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <u>March 23-1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-25-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oldtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oldtown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Beach</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 22 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF BIRTH: [illegible]  
5. PLACE OF BIRTH: [illegible]  
6. OCCUPATION: [illegible]  
7. CAUSE OF DEATH: [illegible]  
8. MANNER OF DEATH: [illegible]  
9. SIGNATURE OF EXAMINER: [illegible]  
10. DATE OF EXAMINATION: [illegible]

BUREAU Y 2

MAR 28 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2693

## CERTIFICATE OF DEATH

02621

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>50 Powell's Lane</u>				d. STREET ADDRESS <u>50 Powell's Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Simeon</u> Middle <u>H.</u> Last <u>Duckworth</u>				4. DATE OF DEATH Month <u>March</u> Day <u>12th</u> Year <u>19 58</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 5th, 1884</u>			
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret.-Md. State</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harrison Duckworth</u>				14. MOTHER'S MAIDEN NAME <u>Mary Lavina Ross</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Howard Duckworth, Rt. 1, Frostburg, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chr. myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. bronchitis</u> DUE TO (c) <u>arterio-sclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u> <u>15 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-1</u> , 19 <u>45</u> , to <u>3-12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-11</u> , 19 <u>58</u> , and that death occurred at <u>2:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>W. Main St.,</u> DATE SIGNED <u>7-10-58</u>									
ACTUAL SIGNATURE <u>H. C. Diehl, M.D.</u>				PHYSICIAN'S NAME (Type) <u>H. C. Diehl, M. D.</u>				Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-14-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>DeLoach</u>			

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 17 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2694

CERTIFICATE OF DEATH

102622

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Lawrence Dunn</b>				4. DATE OF DEATH Month <b>Mar</b> Day <b>31</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 16, 1880</b>		9. AGE (In years last birthday) <b>77</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Officer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Edward Dunn</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Welsh</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Catherine Ward</b> Address <b>Midland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Insufficiency</b> <b>525X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Fibrosis - Asthma</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Midland</b>				(County) <b>Md.</b>		(State)	
21. I certify that I attended the deceased from <b>Mar 12</b> , 1958, to <b>Mar 31</b> , 1958, that I last saw the deceased alive on <b>Mar 31</b> , 1958, and that death occurred at <b>9:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Frostburg</b> DATE SIGNED <b>Apr 1 1958</b>							
ACTUAL SIGNATURE <b>WOMC Lane</b> M.D.				PHYSICIAN'S NAME (Type) <b>WOMC Lane MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Belvedere Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Midland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>				ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>APR 3 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Lane</b>							

"Bye, Bye, Bye"

BUREAU V. 3

APR 7 1958

RECEIVED

2. *Antennae*—

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

FOR STATE  
HEALTH-DEPT.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2632 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02623

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>02</b> <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>John</b> Last <b>Edwards</b>		4. DATE OF DEATH Month <b>March</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 24-1875</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric &amp; Water Commissioner, City of Cumberland, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Mandona Koontz</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-10-1271</b>	
17. INFORMANT <b>(brother) Webster Edwards, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (a), stating the underlying cause lost. DUE TO (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE OF DEATH PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <b>March 3-1958</b>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/4/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Mem. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 6 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. L. Smith</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
STATE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE  
DEPARTMENT OF HEALTH

**RECEIVED**  
MAR 6 1939  
**BUREAU V. S.**

Received 3/11/38  
from the Hon. Gov. M.C.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02624

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>20 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>820 N.Mechanic St.</b>				d. STREET ADDRESS <b>1820 N.Mechanic St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Martin</b> Middle <b>Luther</b> Last <b>Erwin</b>				4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 25-1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Janitor-N.G.Taylor</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Tin Plate Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Carterville, Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>(wife) Annie G. Erwin, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>MAR 25, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAR 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, e. writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director for files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 27 1958

BUREAU V. S.

FOR STATE  
HEALTH DEPT

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2695

## CERTIFICATE OF DEATH

Reg. Dist. No.

02625

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>45 W. College Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LILY</u> Middle <u>(MYERS)</u> Last <u>FARRADY</u>		4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1958</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-16-1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel L. Myers</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Harden</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>none</u>	
17. INFORMANT <u>Mrs. Beulah Williamson, Frostburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>4 mo</u> <u>Seven years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from _____, 19____, to <u>Mar 25</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 24</u> , 19 <u>58</u> , and that death occurred at <u>11:55 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W O McLane M D</u> M.D.		ADDRESS (Street, city or town, state) <u>E. Main St., Frostburg, Md.</u> DATE SIGNED <u>Mar 31</u>	
PHYSICIAN'S NAME (Type) <u>W. O. McLane, M. D.</u>		<u>Frostburg, Md.</u> <u>1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-28-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 2 58</u>		24b. REGISTRAR'S SIGNATURE <u>Ch. Leach</u>	

BURIAL W. B.

APR 2 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02626

Reg. Dist. No.

2634

**FOR STATE  
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>445 Baltimore Ave.</b>				d. STREET ADDRESS <b>445 Baltimore Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Argyle</b> Middle <b>Twigg</b> Last <b>Flake</b>		4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 58</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 18-1876</b>		9. AGE (In years last birthday) <b>81</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Billing Clerk - R. Ry. Express</b>	
11. BIRTHPLACE (State or foreign country) <b>Murleys Branch, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John T. Flake</b>		14. MOTHER'S MAIDEN NAME <b>Martha North</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (daughter) <b>Elizabeth North, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart disease.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>?</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <b>March 24-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 26, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Meth. Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany County, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAR 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAR 27 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2635

## CERTIFICATE OF DEATH

Reg. Dist. No.

02627

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>4 mos</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>404 Washinton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NELLIE</b> Middle <b>WILSON</b> Last <b>FOOTER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>6</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1885</b>
9. AGE (In years lost birthday) <b>72</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>D. Jones Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Marie Josephine McCormick</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Eleanor Murrill, Cumberland, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Left Ventricular Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Arteriosclerosis ?</b> DUE TO (c) <b>Myocardial Fibrosis ?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 23, 1958</b> , to <b>March 6, 1958</b> that I last saw the deceased alive on <b>March 6, 1958</b> , and that death occurred at <b>10:30 M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>March 8, 1958</b>			
ACTUAL SIGNATURE <b>Samuel M. Jacobson</b> M.D.		PHYSICIAN'S NAME (Type) <b>Samuel M. Jacobson M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 6, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>March 11 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	
						</																					

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 269 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02628

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN lb <b>2 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Miners Hospital</b>				d. STREET ADDRESS <b>217 East Main St</b>			
3. NAME OF DECEASED (Type or print) First <b>Genevieve</b> Middle <b>Marie</b> Last <b>Grant</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 2-1888</b>		9. AGE (In years last birthday) <b>69</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Allen McDonald</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Radigan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>(husband) Charles S. Grant, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage (apoplexy)</b> DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>?</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>903.0 Intertrochanteric fracture of left femur.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fractured femur. Walking to bathroom, had a stroke, fell to floor and</b>					
20c. TIME OF INJURY Hour a. m. <b>7 p.m.</b> Month, Day, Year <b>Feb. 28 19 58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Frostburg, Allegany, Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 14-1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cresaptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>MAR 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. H. H.</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAR 17 1958  
BUREAU V. B.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2712

CERTIFICATE OF DEATH

02629

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lenaconing</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Emily</b> Middle <b>Green</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>March</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 9, 1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Middlethian, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Emily Perry</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>William Green</b>		Address <b>Lenaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>"Husband"</b> <b>152.0</b> DUE TO <b>Carcinoma of Duodenum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>metastasis of above to kidneys, etc.</b> DUE TO (c) <b>approx 1 1/2 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>approx 1 1/2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov</b> , 19 <b>58</b> , to <b>March 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 24</b> , 19 <b>58</b> , and that death occurred at <b>12:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John B. Davis</b> M.D. <b>2</b>		ADDRESS (Street, city or town, state) <b>BROADWAY</b>	
PHYSICIAN'S NAME (Type) <b>John B. DAVIS, MD</b>		DATE SIGNED <b>3/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/28/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lenaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lenaconing, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Smith</b>	



MAR 31 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2713

CERTIFICATE OF DEATH

02630

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>CHARLESTOWN STREET</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ESTELLA</b> Middle <b>L.</b> Last <b>GROVES</b>				4. DATE OF DEATH Month <b>3/12/1958</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 7th. 1888</b>	9. AGE (In years lost birthday) <b>70</b>	IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	IF UNDER 24 HRS. Hours <b>70</b> Min. <b>70</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK (OWN HOME)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BARTON, MD.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>STEPHEN LLEWELLYN</b>			
14. MOTHER'S MAIDEN NAME <b>ANNA BELLE MILLER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>NO</b>			
16. SOCIAL SECURITY NO. <b>NONE</b>				17. INFORMANT <b>MR. ANDREW GROVES, LONA CONING, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction (HUSBAND)</b> DUE TO <b>Essential hypertension</b> DUE TO <b>Congestive Heart failure</b> DUE TO <b>Rheumatoid Arthritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>56</b> , to <b>Mar</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Mar. 7</b> , 19 <b>58</b> , and that death occurred at <b>5 P.</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leslie R. Miles Jr.</b> M.D.				ADDRESS (Street, city or town, state) <b>MAIN ST</b> DATE SIGNED <b>3/13/58</b>			
PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES JR.</b>				<b>LONA CONING MD</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/15/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PHILO CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WESTERNPORT, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHORN, LONA CONING, MD.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

MAR 17 1950

RECEIVED

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

7

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
2697 *Item #6* *File # 277-41158-703*  
CERTIFICATE OF DEATH

Reg. Dist. No.

02631

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>39 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>33 Park Avenue</b>				d. STREET ADDRESS <b>33 Park Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Wm.</b> Middle <b>C.</b> Last <b>Hall</b>				4. DATE OF DEATH Month <b>3</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-2-1897</b>	9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>New Kensington, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Cyrus Hall</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W. War II 212 12 8438</b>		17. INFORMANT <b>Mrs. Wm. C. Hall, 33 Park Ave. Frostburg Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>RT Hemiplegia</b> DUE TO (c) <b>Hypertension</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 Hr</b> <b>Several years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 26, 1958</b> , to <b>Mar 28, 1958</b> , that I last saw the deceased alive on <b>Mar 26, 1958</b> , and that death occurred at <b>10:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>WOM Lane</b>		M.D. <b>Frostburg</b>		ADDRESS (Street, city or town, state) <b>Mar 31 1958</b>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>WOM Lane MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-I-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Pk. Frostburg Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. M. Mattingly</b>		ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>APR 7 '58</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

Form No. 10

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF DEATH

PLACE OF DEATH

BUREAU V. 3

APR 7 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3, File G-227 4/11/58, sac

# CERTIFICATE OF DEATH

02632

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>19 BOONE STREET</b>	
3. NAME OF DECEASED (Type or print) First <b>EARL</b> Middle <b>M.</b> Last <b>HANSROTE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>27</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 12, 1892</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED Boilermaker B. &amp; O. R.R.CO.</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JOHN C. HANSROTE</b>		14. MOTHER'S MAIDEN NAME <b>LAURA B. READER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-09-9822</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b> <b>4 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/14/54</b> , 19____, to <b>3/27/58</b> , 19____, that I last saw the deceased alive on <b>3/26/58</b> , 19____, and that death occurred at <b>2:00 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. R.J. WILLIAMS</b>		DATE SIGNED <b>3/28/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-30-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Quinn</b>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 31 1958

RECEIVED



**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02633

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Morantown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural- Morantown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>R.F.D.#2 Frostburg, Md.</b>		d. STREET ADDRESS <b>R.F.D.#2 Frostburg, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Edward</b> Last <b>Henckel</b>		4. DATE OF DEATH Month <b>March</b> Day <b>11</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 27-1899</b>
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b></b> Days <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Morantown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Peter Henckel</b>		14. MOTHER'S MAIDEN NAME <b>Emma C. Logsdon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b></b> (If yes, give war or dates of service) <b></b>		16. SOCIAL SECURITY NO. <b>712-14-1621</b>	
17. INFORMANT Address <b>(wife) Julia W. Henckel, Morantown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b></b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b></b>	
20c. TIME OF INJURY Hour <b></b> a. m. <b></b> p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>	20f. (City or town) (County) (State) <b></b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		DATE SIGNED <b>March 12-1958</b>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		DEPUTY MEDICAL EXAMINER <b></b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 14 '58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		24a. RECEIVED BY REGISTRAR <b>March 17 1958</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. Leach</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAR 17 1959  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use of the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

02634

2637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chamberland</u>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hosp.</u>		d. STREET ADDRESS <u>314 Glenn Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clark</u> Middle <u>E.</u> Last <u>Henry</u>		4. DATE OF DEATH Month <u>March</u> Day <u>12</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 11, 1880</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Insurance Agent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Anita Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry</u>		14. MOTHER'S MAIDEN NAME <u>Eva Schwartz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Mrs. Patrick Hogan</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA, Bronchio -</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>METASTATIC CARCINOMA OF LUNGS</u> DUE TO (c) <u>UNKNOWN</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinoma of Prostate</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>57</u> , to <u>March 12</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 11</u> , 19 <u>58</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. Weisman</u> M.D.		ADDRESS (Street, city or town, state) <u>59 GICEENE ST</u> DATE SIGNED <u>3/12/58</u>	
PHYSICIAN'S NAME (Type) <u>S G WEISMAN M.D.</u>		<u>CUMBERLAND, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/14/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumb Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md</u>		24a. REC'D BY REGISTRAR <u>_____</u> DATE <u>MAR 17 1958</u>	
24b. REGISTRAR'S SIGNATURE <u>_____</u>			

CERTIFICATE OF DEATH

Page One

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

DATE OF DEPARTURE

DATE OF RETURN

DATE OF DEATH

DATE OF BURIAL

DATE OF CREMATION

DATE OF INTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

DATE OF REINTERMENT

BUREAU V. S.

MAR 17 1959

RECEIVED

2715  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cresaptown</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Cresaptown</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. at the Memorial Hospital</b>				d. STREET ADDRESS <b>Along Rt. # 220</b>			
3. NAME OF DECEASED (Type or print) First <b>Ira</b> Middle <b>Joseph</b> Last <b>Hershberger</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>April 29-1916</b>		9. AGE (In years last birthday) <b>41 39</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired- 1940 in army</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Cresaptown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Hershberger</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth McKenzie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war and dates of service) <b>W.W.2</b>				16. SOCIAL SECURITY NO. <b>W.W.2</b>			
17. INFORMANT <b>Thomas Barnes, Cumberland, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary osteal occlusion (left)</b> <b>420.1</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>?</b> (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March.1-1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/4/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Ambrose Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cresaptown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 5 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Red Leach</b>			

BUREAU V. 2

MAR 5 1959

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2638

## CERTIFICATE OF DEATH

Reg. Dist. No.

02636

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>33 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANK</b> Middle <b>J</b> Last <b>HINER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>5</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 4 1892</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer Retail</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self empl.</b>	
11. BIRTHPLACE (State or foreign country) <b>MT. SAVAGE, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES HINER</b>		14. MOTHER'S MAIDEN NAME <b>MARY ANN MILLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>War I</b>		16. SOCIAL SECURITY NO. <b>Frank R Hiner Cumberland 700 Mont. Ave</b>	
17. INFORMANT <b>Frank R Hiner</b>		Address <b>Cumberland 700 Mont. Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Leukemia acute myelogenous</b> DUE TO (b) <b>2043</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>2 months</b> DUE TO (c) <b>2 months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5, 1958</b> to <b>March 5, 1958</b> that I last saw the deceased alive on <b>March 5, 1958</b> and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>James F. Scarpelli</b>		M.D. <b>James F. Scarpelli</b>	
PHYSICIAN'S NAME (Type) <b>DAVID J. REES</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-8-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>10 58</b>		24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>	

CERTIFICATE OF DEATH

ALLIANCE

DECEASED

WHITE

CHURCH

BUREAU V. 1

MAR 10 1958

RECEIVED

2639

## CERTIFICATE OF DEATH

02637

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. STREET ADDRESS <b>1 227 Pear Street</b>	
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>A.</b> Last <b>HORCHLER</b>		4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1888</b>
9. AGE (In years lost birthday) yrs. <b>69</b>		10. IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Brewery</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Horchler</b>		14. MOTHER'S MAIDEN NAME <b>Anna Werner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW 1 214 05 4949</b>	
17. INFORMANT <b>Mrs. Lillian Lehman</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>HYPERTENSIVE HEART DISEASE</b> DUE TO (c) <b>ESSENTIAL HYPERTENSION</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14 HOURS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>481X Acute Upper Respiratory Infection — Influenza</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1948</b> , to <b>March 14, 1958</b> , that I last saw the deceased alive on <b>March 14, 1958</b> , and that death occurred at <b>9:30</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S G WEISMAN</b>		ADDRESS (Street, city or town, state) <b>59 GREENE ST</b>	
PHYSICIAN'S NAME (Type) <b>S G WEISMAN MD</b>		DATE SIGNED <b>3/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/17/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Lukes Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 19 58</b>		24b. REGISTRAR'S SIGNATURE <b>Dehner</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		M		45		JAN 15 1900		BALTIMORE		MD		MD		USA	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		STATE	
LABORER		HEART DISEASE		NATURAL		2 WEEKS		MARCH 10 1945		BALTIMORE		MD		MD	
EDUCATION		RELIGION		MARRIAGE		SINGLE		DATE OF MARRIAGE		PLACE OF MARRIAGE		CITY		STATE	
HIGH SCHOOL		METHODIST		MARRIED		1925		JAN 15 1925		BALTIMORE		MD		MD	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
JAMES H. HARRIS		MARY J. HARRIS		LABORER		HOUSEWIFE		JAN 15 1875		JAN 15 1875		BALTIMORE		BALTIMORE	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH	

BUREAU V. S.

MAR 19 1953

RECEIVED

DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
MARCH 10 1945		BALTIMORE		MD		MD		USA	
NAME OF REGISTRAR		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION		CITY	
JAMES H. HARRIS		[Signature]		MARCH 10 1945		BALTIMORE		MD	

2640

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>208 New Hampshire Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Powers</b> Last <b>Hudson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 12, 1870</b>	
9. AGE (In years lost birthday) yrs. <b>87</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tinplate Mill</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Millwright</b>		11. BIRTHPLACE (State or foreign country) <b>Levels, W. Va.</b>	
13. FATHER'S NAME <b>Robert B. Hudson</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Boor</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Wilbur M. Hudson, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Acute Bronchitis</b> DUE TO (c) <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b> <b>3 wks</b> <b>5 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 5, 1958</b> to <b>Mar. 13, 1958</b> , that I last saw the deceased alive on <b>Mar. 12, 1958</b> , and that death occurred at <b>10:05P</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED							
ACTUAL SIGNATURE <b>Clay E. Durrett</b> M.D.				DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

BUREAU V. S.

MAR 18 1953

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2698

CERTIFICATE OF DEATH

02639

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		d. STREET ADDRESS <b>109 W. Main</b>	
3. NAME OF DECEASED (Type or print) First <b>Jennie</b> Middle <b>E.</b> Last <b>Hunt</b>		4. DATE OF DEATH Month <b>3</b> Day <b>26</b> Year <b>19 58</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-26-1888</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Newton T. Watkins</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Washington, D. C.</b>	
17. INFORMANT <b>Mr. John Hunt (son)</b>		Address <b>90 Webster St., N. E.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Cerebral Hemorrhage</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular</b> DUE TO <b>disease</b> (c) <b>3-4 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-15</b> , 19 <b>55</b> , to <b>3-26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-26</b> , 19 <b>58</b> , and that death occurred at <b>2:05 P.</b> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>H. C. Diehl</b>		M.D. <b>39 W. Main St.</b> DATE SIGNED <b>3/27/58</b>	
PHYSICIAN'S NAME (Type) <b>H. C. Diehl, M.D.</b>		<b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>Burial 3-28-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Pk.</b>	22d. LOCATION (city, town, or county) (State) <b>Frostburg Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul H. Spittingly</b>		24a. REC'D BY REGISTRAR <b>APR 1 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. 2

APR 7 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2699

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b. <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>153 W. Main St.</b>		d. STREET ADDRESS <b>153 W. Main St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CATHERINE</b> Middle <b>NAOMI</b> Last <b>JOYCE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>4</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1906</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James H. Cain</b>		14. MOTHER'S MAIDEN NAME <b>Annie S. Leake</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Anna M. Minnick, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <b>Feb. 19 58</b> to <b>March 4, 19 58</b> , that I last saw the deceased alive on <b>March 3, 19 58</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>John B. Davis, M.D. 1 Broadway</b> PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D. Frostburg, Md.</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Mar. 6, 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b> 23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b> 24a. REC'D BY REGISTRAR <b>APR 7 58</b> 24b. REGISTRAR'S SIGNATURE			

RECEIVED

MAR 7 1958

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2641

## CERTIFICATE OF DEATH

02641

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>229 Wallace St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPHINE</b> Middle <b>PHOEBE</b> Last <b>JUKES</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>2</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1876</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Savage, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Israel Jukes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Mallin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Sarah C. Jukes</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocarditis, Senile degeneration</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis, Senile</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan - 4</b> , 1956, to <b>Feb - 2</b> , 1958, that I last saw the deceased alive on <b>Feb - 2</b> , 1958, and that death occurred at <b>2 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. B. [Signature]</b>		ADDRESS (Street, city or town, state) <b>49 Greene St. Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>49 Greene Street</b>		DATE SIGNED <b>3/3/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/5/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. H. Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. RECEIVED BY REGISTRAR DATE <b>MAR 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

CERTIFICATE OF DEATH

Page One

PLACE TO BE FILLED BY THE REGISTRAR		PLACE TO BE FILLED BY THE REGISTRAR	
NAME OF DECEASED		NAME OF DECEASED	
SEX		SEX	
AGE		AGE	
DATE OF BIRTH		DATE OF BIRTH	
PLACE OF BIRTH		PLACE OF BIRTH	
OCCUPATION		OCCUPATION	
CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH	
DATE OF DEATH		DATE OF DEATH	
PLACE OF DEATH		PLACE OF DEATH	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
DATE OF REGISTRATION		DATE OF REGISTRATION	
OFFICE OF REGISTRATION		OFFICE OF REGISTRATION	
COUNTY		COUNTY	
STATE		STATE	
FEDERAL BUREAU OF INVESTIGATION		FEDERAL BUREAU OF INVESTIGATION	
U.S. DEPARTMENT OF JUSTICE		U.S. DEPARTMENT OF JUSTICE	
WASHINGTON, D.C.		WASHINGTON, D.C.	

BUREAU V. 2

MAR 5 1959

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2716

## CERTIFICATE OF DEATH

02642

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Cumberland</b>		c. LENGTH OF STAY IN 1b <b>17 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>McMullan Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>VIRGINIA</b> Middle <b>JUNKINS</b> Last <b>JUNKINS</b>		4. DATE OF DEATH Month <b>March</b> Day <b>19</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1871</b>
9. AGE (In years last birthday) <b>86 yrs.</b>		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min. <b>86</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Anthony Smith</b>		14. MOTHER'S MAIDEN NAME <b>Catherine</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Charles Dick</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> <b>congestive heart failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>2 years</b> <b>4 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-1-</b> , 19 <b>56</b> , to <b>3-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-18</b> , 19 <b>58</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>L. Brings</b>		ADDRESS (Street, city or town, state) <b>57 Green St. Cumberland Md.</b>	
PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS</b>		DATE SIGNED <b>3-19-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 22, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Elk Garden, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

BUREAU V. 51

MAR 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2717

CERTIFICATE OF DEATH

Reg. Dist. No.

02643

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL, NEAR CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>X RURAL, NEAR CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rt. 1, Cumberland, Md.</b>		d. STREET ADDRESS <b>Rt. 1, Cumberland, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>MARY MARTHA JANE</b> Middle <b>KELLEY</b> Last		4. DATE OF DEATH Month <b>March</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 9, 1861</b>
9. AGE (In years last birthday) <b>96 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gwn Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Fairhope, Penn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Boyer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Jane Null</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George Kelley, Cumberland, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary heart failure</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-2</b> , 19 <b>56</b> , to <b>3-17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-10</b> , 19 <b>58</b> , and that death occurred at <b>9:15 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 W. Main St., Cumberland, Md.</b> DATE SIGNED <b>3-18-58</b> ACTUAL SIGNATURE <b>L. Brings</b> M.D. <b>Louis Brings</b> PHYSICIAN'S NAME (Type) <b>Louis Brings</b> M.D. <b>Greene St., Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 19, 1968</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Savage Meth. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS <b>John J. Hafer, Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>DATE MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. L. ...</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED MURRAY, J. E.		2. SEX Male		3. AGE 38	
4. DATE OF DEATH March 28, 1939		5. TIME OF DEATH 10:15 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. DATE OF MARRIAGE 1925		15. NAME OF SPOUSE Mary E. Murray	
16. NAME OF FATHER John E. Murray		17. NAME OF MOTHER Elizabeth A. Murray		18. NAME OF BIRTHPLACE Baltimore, Md.	
19. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		20. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		21. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
22. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		23. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		24. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
25. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		26. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		27. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
28. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		29. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		30. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
31. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		32. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		33. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
34. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		35. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		36. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
37. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		38. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		39. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
40. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		41. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		42. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
43. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		44. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		45. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
46. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		47. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		48. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
49. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		50. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		51. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
52. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		53. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		54. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
55. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		56. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		57. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
58. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		59. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		60. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
61. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		62. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		63. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
64. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		65. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		66. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
67. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		68. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		69. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
70. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		71. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		72. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
73. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		74. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		75. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
76. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		77. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		78. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
79. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		80. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		81. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
82. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		83. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		84. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
85. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		86. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		87. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
88. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		89. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		90. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
91. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		92. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		93. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
94. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		95. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		96. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
97. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		98. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		99. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	
100. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		101. NAME OF PREVIOUS RESIDENCE Baltimore, Md.		102. NAME OF PREVIOUS RESIDENCE Baltimore, Md.	

RECEIVED  
MAR 28 1939  
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2642

CERTIFICATE OF DEATH

Reg. Dist. No.

02644

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>128 Cumberland St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Mary</u> Last <u>King</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/29/84</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland Cumberland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Geatz</u>				14. MOTHER'S MAIDEN NAME <u>Anna Catherine Bernard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mr. John R. King Charlotte, N. C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia, left lower lobe</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u> <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive and Arteriosclerotic Cardiovascular Disease</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 26, 1958</u> , to <u>March 2, 1958</u> , that I last saw the deceased alive on <u>March 2, 1958</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. F. Doerner Jr.</u>				ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Maryland.</u>			
DATE SIGNED _____				DATE SIGNED _____			
PHYSICIAN'S NAME (Type) <u>W. F. Doerner MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/5/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S. S. Peter &amp; Paul's</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u> ADDRESS <u>Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>6</u> DATE <u>6</u> '58		24b. REGISTRAR'S SIGNATURE <u>Qu...</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

APR 6 1958

RECEIVED





RECEIVED

APR 1 1958

BUREAU V. S.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Scared Heart Hospital</b>		d. STREET ADDRESS <b>13 Laing Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>James</b> Last <b>Lewis</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2-1882</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.	IF UNDER 24 HRS. Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired-Over head Crainman-M.G.Taylor Co</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hollidaysburg, Pa.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Lewis</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>(son) Harry W. Lewis, Cumberland, Md.</b>		Address <b>Seymour St.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>422.1</b> DUE TO <b>Chronic myocarditis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Emphysema</b> (c), stating the underlying cause last, <b>Arteriosclerosis</b> DUE TO <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 15-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-18-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 18 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed with the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 18 1963

BUREAU V. 2

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. RACE: [illegible]  
5. DATE OF DEATH: [illegible]  
6. PLACE OF DEATH: [illegible]  
7. OCCUPATION: [illegible]  
8. CAUSE OF DEATH: [illegible]  
9. MANNER OF DEATH: [illegible]  
10. SIGNATURE OF EXAMINER: [illegible]  
11. DATE OF EXAMINATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2644

## CERTIFICATE OF DEATH

03064

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>ML</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Stanton</b> Middle <b>Litzenburg</b> Last <b>Litzenburg</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/28/76</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Painter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Painter</b>			
11. BIRTHPLACE (State or foreign country) <b>Rainburg Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Hiram L. Litzenburg</b>				14. MOTHER'S MAIDEN NAME <b>Georgiana Fisher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>				16. SOCIAL SECURITY NO. <b>219-03-9683A</b>			
17. INFORMANT <b>Georgiana Litzenburg</b> Address <b>Shutts ML</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 Congestive heart failure</b> DUE TO (b) <b>cardiovascular heart disease</b> DUE TO (c) <b>generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>2 years</b> <b>5 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>4-2-1956</b> , to <b>3-30-1958</b> , that I last saw the deceased alive on <b>3-29-1958</b> , and that death occurred at <b>7:03</b> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. Bries</b>				ADDRESS (Street, city or town, state) <b>576 Green St., Cumberland Md</b>			
DATE SIGNED <b>3-30-58</b>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore City Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>				ADDRESS <b>Cumb. Md.</b>			
24a. REC'D BY REGISTRAR <b>APR 3 '58</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

314

BUREAU V. 2

APR 7 1959

RECEIVED

Received 4/2/58  
 Received from the  
 Baltimore, Md. 314



2645

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>WARWICK &amp; MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>85x-3</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle Last <b>LONG</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 24, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Loader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL LONG</b>		14. MOTHER'S MAIDEN NAME <b>AGNES HART</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>214-05-9275</b>	
17. INFORMANT <b>Mrs. John Long, Wiley Ford, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>433.0</b> DUE TO <b>Admission to Hospital</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Complete Heart Block</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>40 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/23/58</b> , 19____, to <b>3/25/58</b> , 19____, that I last saw the deceased alive on <b>3/25/58</b> , 19____, and that death occurred at <b>11:50 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>RICHARD J. WILLIAMS</b> M.D.		ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>3/26/58</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD J. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-28-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. RECEIVED BY REGISTRAR <b>MAR 28 1958</b> 24b. REGISTRAR'S SIGNATURE <b>W. F. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be checked for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 28 1958

RECEIVED

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2646

## CERTIFICATE OF DEATH

Reg. Dist. No.

02648

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PAW PAW</b>	
c. LENGTH OF STAY IN 1b <b>1 DAY</b>		d. STREET ADDRESS <b>85X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM G.</b> Middle <b>MALCOLM</b> Last		4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN MALCOLM</b>		14. MOTHER'S MAIDEN NAME <b>DELA HARDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Cerebral Vascular Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cerebrovascular Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 10, 1958</b> to <b>March 12, 1958</b> , that I last saw the deceased alive on <b>March 12, 1958</b> , and that death occurred at <b>11:05 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Dr. O. Himmelwright</b> M.D.		ADDRESS (Street, city or town, state) <b>153 Va Ave, Cumberland, Md</b> DATE SIGNED <b>3/14/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. O. HIMMELWRIGHT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/15/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodrow Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Paw Paw, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Helsley</b>		24a. REC'D BY REGISTRAR <b>11817-58</b>	
ADDRESS <b>Berkley Springs, W. Va.</b>		24b. REGISTRAR'S SIGNATURE <b>Overman</b>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

WEST VIRGINIA

DATE OF DEATH

1958

WEST VIRGINIA

DEATH

DEATH

BUREAU V. S.

MAR 17 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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## CERTIFICATE OF DEATH

Reg. Dist. No.

02649

2647

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>	c. LENGTH OF STAY IN 1b <b>24 DAYS</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>624 BALTIMORE AVENUE</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>THOMAS</b> Middle <b>P.</b> Last <b>MC COY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 19, 1874</b>
9. AGE (In years birth day) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>04</b> Days <b>04</b> Hours <b>04</b> Min.	IF UNDER 24 HRS. Months <b>04</b> Days <b>04</b> Hours <b>04</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumb. Steel Co.</b>	11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>EDWIN MC COY</b>	
14. MOTHER'S MAIDEN NAME <b>CAROLINE COOK</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Hypertension</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/23/58</b> , 19 <b>58</b> , to <b>3/26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/26</b> , 19 <b>58</b> , and that death occurred at <b>2:10 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Maryland</b> DATE SIGNED <b>3/27/58</b> ACTUAL SIGNATURE <b>George M. Simon</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. GEORGE M. SIMONS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March, 28, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		24a. REC'D BY REGISTRAR <b>APR 1 1958</b>	
ADDRESS <b>Cumberland, Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. S.

APR 1 1958

RECEIVED



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2700

CERTIFICATE OF DEATH

Reg. Dist. No.

02650

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport</b>		c. LENGTH OF STAY IN 1b <b>33 Yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>519* Md. Ave</b>		d. STREET ADDRESS <b>519 Md. Ave</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Roland</b> Last <b>McGowan</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>29</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1897</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Locomotive Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Papaer Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Piedmont, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert McGown</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Peck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1</b>	
17. INFORMANT <b>Mary McGown</b>		Address <b>Westernport, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> <b>Coronary Arterial Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>18 Months</b> (c) <b>18 Months</b>		INTERVAL BETWEEN ONSET AND DEATH <b>18 Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 27</b> , 19 <b>56</b> , to <b>Mar 29</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Mar 24</b> , 19 <b>58</b> , and that death occurred at <b>5:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Paul R. Wilson</b> M.D.		DATE SIGNED <b>3-31-58</b>	
PHYSICIAN'S NAME (Type) <b>Paul R. Wilson M.D.</b>		ADDRESS (Street, city or town, state) <b>Piedmont, W.Va.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/31/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Philos Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>El Boal</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

RECEIVED

APR 3 1958

BUREAU V. 1

1. NAME OF DECEASED [REDACTED]		2. DATE OF DEATH [REDACTED]	
3. PLACE OF DEATH [REDACTED]		4. PLACE OF BIRTH [REDACTED]	
5. SEX [REDACTED]		6. RACE [REDACTED]	
7. AGE [REDACTED]		8. OCCUPATION [REDACTED]	
9. MARITAL STATUS [REDACTED]		10. EDUCATION [REDACTED]	
11. RELIGION [REDACTED]		12. SOCIAL SECURITY NUMBER [REDACTED]	
13. SIGNATURE OF DECEASED [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	
15. SIGNATURE OF DECEASED [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF DECEASED [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. SIGNATURE OF DECEASED [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]	
23. SIGNATURE OF DECEASED [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF DECEASED [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]	
27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF DECEASED [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	
31. SIGNATURE OF DECEASED [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]	
35. SIGNATURE OF DECEASED [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF DECEASED [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]	
39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF DECEASED [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF DECEASED [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]	
47. SIGNATURE OF DECEASED [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF DECEASED [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]	
51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF DECEASED [REDACTED]		54. SIGNATURE OF WITNESS [REDACTED]	
55. SIGNATURE OF DECEASED [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]	
59. SIGNATURE OF DECEASED [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF DECEASED [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]	
63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF DECEASED [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]	
67. SIGNATURE OF DECEASED [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]	
71. SIGNATURE OF DECEASED [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
73. SIGNATURE OF DECEASED [REDACTED]		74. SIGNATURE OF WITNESS [REDACTED]	
75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF DECEASED [REDACTED]		78. SIGNATURE OF WITNESS [REDACTED]	
79. SIGNATURE OF DECEASED [REDACTED]		80. SIGNATURE OF WITNESS [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]	
83. SIGNATURE OF DECEASED [REDACTED]		84. SIGNATURE OF WITNESS [REDACTED]	
85. SIGNATURE OF DECEASED [REDACTED]		86. SIGNATURE OF WITNESS [REDACTED]	
87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF DECEASED [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]	
91. SIGNATURE OF DECEASED [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]	
95. SIGNATURE OF DECEASED [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF DECEASED [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]	
99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2701

## CERTIFICATE OF DEATH

Reg. Dist. No.

02651

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>10 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>138 Wood Street</b>				d. STREET ADDRESS <b>138 Wood Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARTHA</b> Middle <b>McMILLAN</b> Last <b>McMILLAN</b>				4. DATE OF DEATH Month <b>March</b> Day <b>30</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 26, 1867</b>	
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>91</b> Days <b>91</b> Hours <b>91</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Scotland</b>	
13. FATHER'S NAME <b>James T. Lee</b>				14. MOTHER'S MAIDEN NAME <b>Janet Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>none</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Mrs. Timothy Fuller, Frostburg, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arterio-sclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m. Month, Day, Year				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frostburg, Md.</b>				20g. (County) <b>Frostburg, Md.</b>			
21. I certify that I attended the deceased from <b>Oct 19, 1957</b> to <b>Mar 30, 1958</b> , that I last saw the deceased alive on <b>Mar 26, 1958</b> , and that death occurred at <b>10:00 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W O McLane MD</b>				M.D. <b>E. Main St.</b> DATE SIGNED <b>Mar 31 1958</b>			
PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4-2-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>				ADDRESS			
24a. REC'D BY REGISTRAR <b>APR 2 58</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>			

CERTIFICATE OF DEATH

Form 10-1-1

1. Name of Deceased

2. Sex

3. Date of Birth

4. Place of Birth

5. Date of Death

6. Place of Death

7. Cause of Death

8. Manner of Death

9. Signature of Physician

10. Signature of Registrar

11. Date of Entry

12. Place of Entry

13. Name of Hospital

14. Name of Doctor

15. Name of Nurse

16. Name of Assistant

17. Name of Attendant

18. Name of Witness

19. Name of Coroner

20. Name of Jury

21. Name of Jury Foreman

22. Name of Jury Clerk

23. Name of Jury Stenographer

24. Name of Jury Interpreter

25. Name of Jury Translator

26. Name of Jury Interpreter

27. Name of Jury Translator

28. Name of Jury Interpreter

29. Name of Jury Translator

30. Name of Jury Interpreter

31. Name of Jury Translator

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49. Name of Jury Translator

50. Name of Jury Interpreter

51. Name of Jury Translator

52. Name of Jury Interpreter

53. Name of Jury Translator

54. Name of Jury Interpreter

55. Name of Jury Translator

56. Name of Jury Interpreter

57. Name of Jury Translator

58. Name of Jury Interpreter

59. Name of Jury Translator

60. Name of Jury Interpreter

BUREAU V. B.

APR 2 1938

RECEIVED

2702

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>187 E. Main St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>McNEIL</b> Last <b>McNEIL</b>				4. DATE OF DEATH Month <b>March</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3, 1877</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kelly-Spgfd. Tire Co.</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>William McNeil</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth McNeil</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>218-16-3712</b>		17. INFORMANT Address <b>Mrs. Elizabeth McNeil, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X cerebral accident</b> DUE TO <b>arteriosclerosis &amp; Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>years -</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>July 1949</b> to <b>March 1, 1958</b> , that I last saw the deceased alive on <b>March 4, 1958</b> , and that death occurred at <b>4:30 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Broadway, Frostburg, Md.</b> DATE SIGNED <b>John B. Davis, M. D.</b>							
ACTUAL SIGNATURE <b>John B. Davis, M. D.</b>							
PHYSICIAN'S NAME (Type) <b>John B. Davis, M. D.</b>				<b>Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-4-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 6 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

1930

BUREAU V. 2

MAR 6 1930

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G226 3-24-58 et

2648

CERTIFICATE OF DEATH

02653

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>002 CUMBERLAND,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL AVE. MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>720 R LAFAYETTE AVE.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>MR. CHARLES W. MEEKS</b> First Middle Last				4. DATE OF DEATH Month <b>MARCH</b> Day <b>6</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/26/1875</b>	
9. AGE (In years last birthday) <b>82 1/2 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tin Plate Mill</b>		11. BIRTHPLACE (State or foreign country) <b>W.VA. Paw Paw</b>	
13. FATHER'S NAME <b>DAVID MEEKS</b>				14. MOTHER'S MAIDEN NAME <b>LUCRETIA FEITERS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>10 yrs</b>							INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2 March 1958</b> , to <b>6 March, 19 58</b> , that I last saw the deceased alive on <b>6 March, 19 58</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 So. Centre St., Cumberland Md.</b> DATE SIGNED <b>8 March 58</b>							
ACTUAL SIGNATURE <b>James G. Stegmaier</b>		PHYSICIAN'S NAME (Type) <b>James G. Stegmaier 122 So. Centr. St. Cumberland Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Camp Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pa Paw, West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b> ADDRESS				24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Leach</b>	

RECEIVED

MAR 11 1959

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE  
CERTIFICATE OF DEATH

NAME: CHARLES W. [REDACTED]  
AGE: 45 YEARS  
SEX: MALE  
RACE: WHITE  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
OCCUPATION: [REDACTED]  
EDUCATION: [REDACTED]  
MARRIAGE: [REDACTED]  
PREVIOUS ILLNESS: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
SIGNATURE: [REDACTED]  
TITLE: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2649

## CERTIFICATE OF DEATH

Reg. Dist. No. 02654

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 535 NEWTON STREET			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First KAREN Middle V. Mercer Last				4. DATE OF DEATH Month MARCH Day 23 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 7, 1958	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) KEYSER, W.VA.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRANK MERCER				14. MOTHER'S MAIDEN NAME EUNICE WILT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)			
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bacterial</u> DUE TO (b) <u>Emphysema - Surgically removed</u> DUE TO (c) <u>Congenital Cerebral</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patent Foramen Ovale</u> INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar 7</u> , 19 <u>58</u> to <u>Mar 23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 23</u> , 19 <u>58</u> , and that death occurred at <u>12:38</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Dr. Louis Mould</u>				ADDRESS (Street, city or town, state) <u>120 S. Antietam Cumberland, Md.</u>			
DATE SIGNED							
PHYSICIAN'S NAME (Type) DR. LOUIS MOULD							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Mar. 24/58</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Westport Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. F. Fudlock</u>				ADDRESS <u>P. Piedmont, W. Va.</u>			
24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Al. Beach</u>			

# CERTIFICATE OF DEATH

MAR 31 1968

RECEIVED

BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G227, 4/16/58

## CERTIFICATE OF DEATH

Reg. Dist. No. 02655

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>18 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPRING GAP, MD.</b>	
3. NAME OF DECEASED (Type or print) First <b>HELEN</b> Middle <b>BURNS</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 1st, 1912</b>
9. AGE (In years last birthday) <b>46 1/2 yrs.</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>15</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>W. VA.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEBLEGA BURNS</b>		14. MOTHER'S MAIDEN NAME <b>GRACE IRVIN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None.</b>	
17. INFORMANT <b>HUSBAND</b>		Address <b>SAME ADDRESS</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>General Peritonitis</b> DUE TO <b>Perforated Ulcer of Jejunum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Acute Gastro-Enteritis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b> <b>9 hours</b> <b>One week</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 20, 1958</b> to <b>March 27, 1958</b> , that I last saw the deceased alive on <b>March 27, 1958</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. J. Johnson</b>		DATE SIGNED <b>3-29-58</b>	
PHYSICIAN'S NAME (Type) <b>J. J. Johnson</b>		ADDRESS (Street, city or town, state) <b>Cumberland, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/29/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumb. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Sr.</b>		ADDRESS <b>Cumb. Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 2 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

BUREAU V. S.

APR 2 1959

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2651

## CERTIFICATE OF DEATH

02656

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PAW PAW, W. VA.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL, MEMORIAL AVE.</b>				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>MRS. BESSIE L. MORELAND</b>				4. DATE OF DEATH Month Day Year <b>MARCH 6 1958</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>SEPT. 27, 1896</b>		9. AGE (In years last birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife- Home</b>		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) <b>GORE, VA.</b>	
14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		15. FATHER'S NAME <b>ADEN CATLETT</b>		16. MOTHER'S MAIDEN NAME <b>ETTA STOTLER STOTLER</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO.		19. INFORMANT Address <b>MEMORIAL HOSPITAL, CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerosis</b> DUE TO (c) <b>vasculor dis</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 day</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from <b>2-4-1958</b> to <b>3-6-1958</b> , that I last saw the deceased alive on <b>3-6-1958</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W.F. Williams</b>		M.D.		ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>3-7-58</b>	
PHYSICIAN'S NAME (Type) <b>W.F. Williams</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>March 9, 1958</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Grove Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Near Levels, W. Va.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.H. McKee</b>		ADDRESS <b>Augusta, W. Va.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. McKee</b>					

971-25

10

BUREAU V. S.

MAR 11 1959

RECEIVED

Item 18 Film 227 4-3-58 ams

2652

## CERTIFICATE OF DEATH

Reg. Dist. No.

02657

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS <b>317 PEARL ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>CHRISTIAN</b>		First <b>CHRISTIAN</b>		Middle <b>MORTZFELDT</b>		Last <b>MORTZFELDT</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 2, 1894</b>	
				9. AGE (In years lost birthday) yrs. <b>63</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Elly-Springfield</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST MORTZFELDT</b>		Tire Co.		14. MOTHER'S MAIDEN NAME <b>ELIZABETH REICH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>317 Pearl Street Mrs. Rose Mortzfeldt Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>570.5</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Post-operative (Abdominal</b> DUE TO (c) <b>Laparotomy</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Operation for intestinal obstruction due to abdominal adhesions.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/11</b> , 19 <b>58</b> , to <b>3/12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/12</b> , 19 <b>58</b> , and that death occurred at <b>12.01 PM</b> , from the causes and on the date stated above <b>Leo H. Ley Jr.</b> ADDRESS (Street, city or town, state) <b>456 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>3/19/58</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>LEO H. LEY</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 20, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Reich</b>	

CERTIFICATE OF DEATH

Page No. 1

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DECEASED

CAUSE OF DEATH

DATE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

SEX

CAUSE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

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CAUSE OF DEATH

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

SEX

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DECEASED

FILE NO.

DATE OF DEATH

PLACE OF DEATH

DECEASED

BUREAU Y. S.

MAR 26 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH—BALTIMORE, 18

Item #7 - Film G227 - 1/10/58 - mb

03065

2653

# CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> MARYLAND		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <b>St. Gerard's Ave</b>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Bernard</b> Middle <b>Mullan</b> Last <b>Mullan</b>		<b>4. DATE OF DEATH</b> Month <b>3</b> Day <b>31</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>3/3/58:85</b>
9. AGE (In years lost birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired train dispatcher-W.Md R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William T. Mullan</b>		14. MOTHER'S MAIDEN NAME <b>Anna Carlos</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>712-14-1572</b>	
17. INFORMANT <b>Patient's chart</b>		Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331X</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-2</b> , 19 <b>58</b> , to <b>3-31</b> , 19 <b>58</b> , that I lost saw the deceased alive on <b>3-31</b> , 19 <b>58</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St.</b> DATE SIGNED <b>3-31-58</b>			
ACTUAL SIGNATURE <b>Ralph W. Ballin</b>		M.D. <b>62 Greene St.</b>	
PHYSICIAN'S NAME (Type) <b>Ralph W. Ballin, M.D.</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR <b>APR 7 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2654

CERTIFICATE OF DEATH

02658

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>ALLEGANY</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>				c. LENGTH OF STAY IN 1b <u>6 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 CUMBERLAND</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>				d. STREET ADDRESS <u>1 206 PARK ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>GENEVIEVE</u> Middle <u>CECELIA</u> Last <u>MYERS</u>				<b>4. DATE OF DEATH</b> Month <u>MAR</u> Day <u>CH</u> Year <u>10 19 58</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 13, 1901</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>XXXXXX Caledonia, Minn</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>HENRY MULLIGAN (DECEASED)</u>				14. MOTHER'S MAIDEN NAME <u>Honora Mulligan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PT'S CHART</u> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/5</u> , 19 <u>58</u> , to <u>3/10</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>58</u> , and that death occurred at <u>5:45A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>3/10/58</u> ACTUAL SIGNATURE <u>Leo H. Iley Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>LEO H. ILEY, JR., M.D.</u> <u>456 N. CENTRE ST., CUMBERLAND, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>March 12, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u> ADDRESS <u>Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Quel...</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		MEDICAL HISTORY [REDACTED]	
SIGNATURE OF PHYSICIAN [REDACTED]		SIGNATURE OF CORONER [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]	

**RECEIVED**  
 MAR 19 1939  
 BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
DR. HIMMELWRIGHT					2655 CERTIFICATE OF DEATH					02659									
1. PLACE OF DEATH										2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)									
a. COUNTY ALLEGANY					MARYLAND					b. COUNTY ALLEGANY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,					c. LENGTH OF STAY IN 1b 6 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL					d. STREET ADDRESS 503 MARYLAND AVENUE					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) VERA					First Middle Last NAVE					4. DATE OF DEATH Month Day Year MARCH 23 1958									
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 6, 1884			9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.			12. CITIZEN OF WHAT COUNTRY? USA								
13. FATHER'S NAME William R. Fisher <del>XXXXXXXXXXXX</del>					14. MOTHER'S MAIDEN NAME Mary V. Dodd														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none			17. INFORMANT Charles W. Fisher, Cumberland, Md.											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>B, LATERAL LOBAR PNEUMONIA</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____															19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>3/17</u> , 19 <u>58</u> , to <u>3/23</u> , 19 <u>58</u> , that I last saw the deceased alive on _____, 19____, and that death occurred at <u>10:50 A.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>George M. Simons</u> M.D. <u>12845</u> PHYSICIAN'S NAME (Type) <u>DR. SIMONS</u> <u>Cumberland Md</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 3-26-58					22c. NAME OF CEMETERY OR CREMATORY I. O. O. F. Cemetery					22d. LOCATION (City, town, or county) (State) Centerville, Pa.				
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.										24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>					24b. REGISTRAR'S SIGNATURE <u>Red Smith</u>				

RECEIVED

MAR 26 1938

BUREAU Y. S.

2656

## CERTIFICATE OF DEATH

02660

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>26 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>137 Virginia Ave.</b>				d. STREET ADDRESS <b>643 Hilltop Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Marlow</b> Last <b>Orrison</b>				4. DATE OF DEATH Month <b>Mar.</b> Day <b>13</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 28, 1882</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Appliance Store</b>		11. BIRTHPLACE (State or foreign country) <b>Frederick County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles G. Orrison</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>214-05-5635</b>		17. INFORMANT <b>Glenn E. Orrison, Frederick, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Arteriosclerosis Generalized</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Frederick, Md.</b>				20g. (County) <b>Frederick, Md.</b>			
20h. (State) <b>Md.</b>							
21. I certify that I attended the deceased from <b>Jan. 9, 1958</b> to <b>March 13, 1958</b> , that I last saw the deceased alive on <b>March 13, 1958</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>133 Virginia Ave. Cumberland, Md.</b> DATE SIGNED <b>March 14, 1958</b>							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. <b>133 Virginia Ave. Cumberland, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Dr. G. Overton Himmelwright</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 17 1938

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2657

# CERTIFICATE OF DEATH

02661

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>Jennings</b> Last <b>Ott</b>				4. DATE OF DEATH Month <b>3</b> Day <b>17</b> Year <b>58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1900</b>		9. AGE (In years last birthday) <b>57</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trainman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B.&amp;O. RR</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia, Terra Alta</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Ott</b>				14. MOTHER'S MAIDEN NAME <b>Gora R. Niner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-1P-1584</b>		17. INFORMANT <b>Pt's chart.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, RUL, RML</b> <b>480x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INFLUENZA</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROTIC HEART DISEASE - CORONARY SCLEROSIS</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/16/58</b> to <b>3/17/58</b> , that I last saw the deceased alive on <b>3/16/58</b> , and that death occurred at <b>12:25 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Almeida</b>		M.D. <b>59</b>		ADDRESS (Street, city or town, state) <b>Cumberland</b>		DATE SIGNED <b>3/17/58</b>	
PHYSICIAN'S NAME (Type) <b>S E WEISMAN MD</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/20/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Almeida</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. JONES		Male		35		White		1925		Baltimore, Md.		1960		Baltimore, Md.		Heart Disease		Natural		J. H. Jones		J. H. Jones	
13. MARITAL STATUS		14. OCCUPATION		15. EDUCATION		16. RELIGION		17. SOCIAL SECURITY NUMBER		18. PREVIOUS MARRIAGES		19. PREVIOUS DEATHS		20. PREVIOUS ILLNESSES		21. PREVIOUS SURGERIES		22. PREVIOUS DRUGS		23. PREVIOUS ALCOHOL		24. PREVIOUS TOBACCO	
Married		Teacher		High School		Catholic		123-456789		None		None		None		None		None		None		None	
25. SIGNATURE OF WITNESSES		26. SIGNATURE OF DECEASED		27. SIGNATURE OF REGISTRAR		28. SIGNATURE OF DECEASED		29. SIGNATURE OF REGISTRAR		30. SIGNATURE OF DECEASED		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF DECEASED		33. SIGNATURE OF REGISTRAR		34. SIGNATURE OF DECEASED		35. SIGNATURE OF REGISTRAR		36. SIGNATURE OF DECEASED	
J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones		J. H. Jones	

RECEIVED  
MAR 26 1960  
BUREAU V. E.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2703

## CERTIFICATE OF DEATH

Reg. Dist. No. 02662

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jane</b> Middle <b>Park</b> Last <b>Park</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 31, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Lonaconing, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Jones</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Bradley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Nell McCormick</b>		Address <b>Lonaconing, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1. Anti Coronary Occlusion</b> DUE TO (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>20 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/26</b> , 19 <b>58</b> , to <b>3/27</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/27</b> , 19 <b>58</b> , and that death occurred at <b>6:55 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Martin M. Rothstein M.D.</b>		ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED <b>3/29/58</b>	
PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D.</b>		<b>FROSTBURG - M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/30/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Md.</b>	
24a. REC'D BY REGISTRAR <b>APR 1 '58</b>		24b. REGISTRAR'S SIGNATURE <b>And...</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

BUREAU V. 8

APR 1 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2658

## CERTIFICATE OF DEATH

Reg. Dist. No.

02663

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. LENGTH OF STAY IN 1b <u>3 Days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SACRED HEART HOSPITAL</u>		d. STREET ADDRESS <u>822 WINDSOR ROAD</u>	
3. NAME OF DECEASED (Type or print) First <u>ATMA</u> Middle <u>A.</u> Last <u>PIPER</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>20</u> Year <u>19 58</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 29, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Michigan</u>
13. FATHER'S NAME <u>Eri M. Kenyon</u>		14. MOTHER'S MAIDEN NAME <u>Ella ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212 01 9321B</u>	
17. INFORMANT <u>Wm. E. Piper</u>		Address <u>Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Memia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 days, 1 year,</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) _____			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D. <u>43</u>		ADDRESS (Street, city or town, state) <u>3143 Garrett Cumberland Md</u> DATE SIGNED <u>3/1/58</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/24/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Portland Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Portland Michigan</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Byron Knight</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REG'D BY REGISTRAR <u>MAR 24 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. E. Piper</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED: [blank]  
2. SEX: [blank] 3. AGE: [blank] 4. DATE OF BIRTH: [blank]  
5. PLACE OF BIRTH: [blank] 6. OCCUPATION: [blank]  
7. CAUSE OF DEATH: [blank]  
8. PLACE OF DEATH: [blank]  
9. DATE OF DEATH: [blank]  
10. SIGNATURE OF PHYSICIAN: [blank]  
11. SIGNATURE OF REGISTRAR: [blank]  
12. SIGNATURE OF WITNESS: [blank]

BUREAU V. 2

MAR 24 1950

RECEIVED



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02664

2719

Item 14 Film G227 3-28-58 et

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Allegheny</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corriganville</u> c. LENGTH OF STAY IN 1b <u>12 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.F.D.#1, Hyndman, Pa.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Allegheny</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.F.D.#1, Hyndman - Corriganville</u> d. STREET ADDRESS <u>P.F.D.#1, Hyndman</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>TILLIE K. PORTER</u>				4. DATE OF DEATH Month Day Year <u>Mar. 15 1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1879</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U. S. Q. (Pa)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>William Kendall</u>				14. MOTHER'S MAIDEN NAME <u>Louise Bone</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John Porter, P.F.D.#4, Meyersdale</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary sclerosis</u> (c) <u>Arteriosclerosis</u> DUE TO cause last. INTERVAL BETWEEN ONSET OF DEATH <u>Sudden</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Daming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>H. V. Daming M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>March 15-1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-18-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Temple Church Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>P.F.D.#4, Meyersdale, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. P. Konlows</u>				ADDRESS <u>Meyersdale Pa.</u>		MAILED BY REGISTRAR <u>Mar 24 '58</u> DATE	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

RECEIVED  
MAR 24 1938  
BUREAU V. 4

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02665

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

M

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		d. STREET ADDRESS <b>/310 Waverly Terrace</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Phillip</b> Middle <b>E</b> Last <b>Portmess</b>		4. DATE OF DEATH Month <b>March</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21-1925</b>
9. AGE (In years last birthday) <b>32</b> yrs.		IF UNDER 1 YEAR Months <b>32</b> Days <b>32</b> Hours <b>32</b> Min. <b>32</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O.R.Ry.</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Vernon E. Portmess</b>		14. MOTHER'S MAIDEN NAME <b>Lear G. Weller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.#2 219-14-5886</b>	
17. INFORMANT <b>(sister) &amp; Memorial Hospital records.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral edema (marked)</b> DUE TO <b>900.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Atelectasis of both lungs</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 days</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell over wall &amp; down 5 concrete steps.</b>	
20c. TIME OF INJURY Month, Day, Year <b>11-20-3-17/58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Front of home</b>		20f. (City or town) (County) (State) <b>Cumberland Allegany Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 21-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/24/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland, Maryland.</b>	
24a. REGD. BY REGISTRAR <b>March 24-58</b>		24b. REGISTRAR'S SIGNATURE <b>Ruth E. Silcox</b>	
DATE			

about

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 24 1938

BUREAU V. 21

FOR STATE  
HEALTH DEPT



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2720

CERTIFICATE OF DEATH

02666

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u> c. LENGTH OF STAY IN 1b <u>Life</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Vale Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>120 Park Ave.</u>		d. STREET ADDRESS <u>120 Park Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Thomas</u> Last <u>Pritchard</u>		4. DATE OF DEATH Month <u>March</u> Day <u>11</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1872</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (State or foreign country) <u>Upshure Co. N. Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Watson Pritchard</u>	
14. MOTHER'S MAIDEN NAME <u>Elizabeth Shore</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>—</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Miss Gerardine Pritchard, La Vale Md.</u>	
18. CAUSE OF DEATH [Enter only one cause partline for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>10</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/4/53</u> , 19 <u>  </u> , to <u>3/10/58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>2/28/58</u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>3/10/58</u>	
PHYSICIAN'S NAME (Type) <u>  </u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>3/13/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cem.</u>	
22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb-Md</u>	
24a. REC'D BY REGISTRAR <u>  </u> DATE <u>MAR 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	







## CERTIFICATE OF DEATH

02667

Reg. Dist. No.

2660

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND,</b>		c. LENGTH OF STAY IN 1b <b>4 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EVA</b> Middle <b>ELIZABETH</b> Last <b>RACEY</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>21</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 29, 1891</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Ownhome</b>	
11. BIRTHPLACE (State or foreign country) <b>Martinsburg, WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN MORAN</b>		14. MOTHER'S MAIDEN NAME <b>DORA Schad</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Darriell J. Racey</b>		Address <b>15 W. Second St</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes Mellitus and</b> DUE TO <b>Arteriosclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>6 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/7/52</b> , 19 <b>52</b> , to <b>3/21/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/21/58</b> , 19 <b>58</b> , and that death occurred at <b>7:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>3/21/58</b>			
ACTUAL SIGNATURE <b>R. J. Williams</b> M.D.		PHYSICIAN'S NAME (Type) <b>R. J. WILLIAMS, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. Schuch</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU Y. S.

MAR 26 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02668

2661

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Philadelphia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Memorial Hospital</b>		e. STREET ADDRESS <b>5820 Baltimore Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>LOUIS</b> Middle <b>EDWARD</b> Last <b>RICE</b>		4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 25, 1901</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>17</b>	11. IF UNDER 24 HRS. Hours <b>17</b> Min. <b>3</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Elmer Edward Rice</b>		14. MOTHER'S MAIDEN NAME <b>Althea Rose Shaw</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>5820 Baltimore Avenue</b>	
17. INFORMANT <b>Ramon L. Rice</b>		<b>Philadelphia, Pennsylvania</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Cardiac Failure</b> DUE TO <b>422.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to Fatty Heart</b> DUE TO <b>Obesity Cardiac Hypertrophy</b> (c) <b>Sudden</b> INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED?</b> <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 11</b> , 19 <b>58</b> , to <b>March 12</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>March 11, 1958</b> , and that death occurred at <b>1:35 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>240 N. Centre St. Cumberland, Md.</b> DATE SIGNED <b>3-13-58</b>			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		M.D. <b>240 N. Centre St. Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>H.V. Deming</b>		M.D. <b>240 North Centre Street, Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>March 15, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 17 1958</b>	
24b. REGISTRAR'S SIGNATURE			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02669

Reg. Dist. No.

2662

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W.Va.</b> b. COUNTY <b>Hampshire</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>3 weeks</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>623 Maryland Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Hampton</b> Middle <b>Steven</b> Last <b>Roach</b>				4. DATE OF DEATH Month <b>March</b> Day <b>7</b> Year <b>1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 9-1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>2</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Kopper Tie Plant B&amp;O.</b>		11. BIRTHPLACE (State or foreign country) <b>Springfield, W.Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>David Roach</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Orndorf</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>(daughter) Mrs. Margaret Taylor, Cumberland</b>			
17. INFORMANT <b>Md.</b>				Address <b>Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Sclerotic heart disease</b> (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>8 yrs</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>0</b> m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 8-1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-10-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Springfield Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Springfield, W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Shaffer Funeral Home Romney, W.Va.</b>				24a. REC'D BY REGISTRAR <b>MAR 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Beach</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death.

FOR STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAR 10 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02670

2663

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GEORGE</b> Middle <b>Wm.</b> Last <b>ROBINSON</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>16</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 18, 1915</b>
9. AGE (In years last birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, none if retired) <b>KREMER BROS FREIGHT LINE Driver</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>ROBINSON, MARY HOWARD C.</b>	
14. MOTHER'S MAIDEN NAME <b>DOLLY KISER</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-05-8076</b>		17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO <b>480X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>INFLUENZA</b> DUE TO <b>6 days</b> (c) <b>6 days</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>MITRAL STENOSIS — inactive Rheumatic Heart Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1957</b> , to <b>March 16, 1958</b> , that I last saw the deceased alive on <b>March 15, 1958</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. G. Weisman</b> M.D.		DATE SIGNED <b>3/17/58</b>	
PHYSICIAN'S NAME (Type) <b>S. G. WEISMAN MD</b>		<b>Cumberland, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/19/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Concord Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Belington, W.Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR <b>MAR 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Reese</b>			

2235

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2508-1941

**BURBANK**

MAR 26 1958

RECEIVED

**1** hours after death. The law requires that the death certificate be executed within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## CERTIFICATE OF DEATH

2661

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ALLEGANY</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>ALLEGANY</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>CUMBERLAND</u>		LENGTH OF STAY (in this place) <u>2 yrs. 8 mos.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CRESAPTOWN MD.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>ALLEGANY CO. INFIRMARY</u> <u>CUMBERLAND</u>				STREET ADDRESS (If rural give location) <u>Warriors Drive</u>			
<b>3. NAME OF DECEASED</b> (First) <u>SAMUEL</u> (Middle) <u>LEVI</u> (Last) <u>Robison</u>				<b>4. DATE OF DEATH</b> (Month) <u>MAR.</u> (Day) <u>15</u> (Year) <u>1958</u>			
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>M</u>	<b>8. DATE OF BIRTH</b> <u>AUG. 21, 1866</u>		<b>9. AGE last birthday</b> <u>91</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired FARMER</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Farm owner</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Cresaptown, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>LEVI Robison</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>AMANDA Jackson</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MRS. PEARL SHEPHERD</u> <u>CRESAPTOWN MD.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>IMMEDIATE CAUSE (A)</b> <u>592X CHRONIC MYOCARDITIS</u>						<u>?</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>GENERAL ARTERIOSCLEROSIS</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)</b> <u>CHRONIC NEPHRITIS</u>						<u>?</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>SENILE DETERIORATION</u>						<u>?</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>AUG. 8, 1953</u> , to <u>MAR. 15, 1958</u> , that I last saw the deceased alive on <u>MAR. 15, 1958</u> , and that death occurred at <u>9:30 A.M.</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>James E. McLean</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>49 GREENE ST.</u>		<b>DATE SIGNED</b> <u>3-15-58</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>3-17-1958</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Dawson Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Dawson, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>MAR 17 '58</u>		<b>REGISTRAR'S SIGNATURE</b> <u>W. E. Smith</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles L. George</u> <u>Cumberland, Md.</u>			

CERTIFICATE OF DEATH

Form 10-1-1933

A. USUAL RESIDENCE HOME OR OTHER PLACE

DATE

PLACE

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

BURKAW V. S.

MAR 17 1933

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02672

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>35 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>2 South Terrace</b>				d. STREET ADDRESS <b>1 2 South Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Irvin</b> Last <b>Roby Sr.</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 12-1900</b>		9. AGE (In years last birthday) <b>57 yrs.</b>	IF UNDER 1 YEAR Months <b>57</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O.R.Ry.</b>		11. BIRTHPLACE (State or foreign country) <b>Paw Paw, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Heberly Roby</b>				14. MOTHER'S MAIDEN NAME <b>Maggie E. Stickly</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give was or dates of service) <b>W.W.1 705-05-4608</b>		17. INFORMANT Address <b>(wife) Elva Roby, Cumberland, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cystic degeneration of brain (frontal lobe)</b> <b>about 6 months.</b>							
223 x DUE TO (b) <b>Cerebral edema (marked)</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <b>Coronary sclerosis</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m. <b>0</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 25-1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/27/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Frostburg Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 31 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. L. Leach</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained to files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 31 1958

BUREAU V. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: \_\_\_\_\_  
2. Sex: \_\_\_\_\_  
3. Age: \_\_\_\_\_  
4. Date of Birth: \_\_\_\_\_  
5. Place of Birth: \_\_\_\_\_  
6. Usual Residence: \_\_\_\_\_  
7. Date of Death: \_\_\_\_\_  
8. Time of Death: \_\_\_\_\_  
9. Place of Death: \_\_\_\_\_  
10. Cause of Death: \_\_\_\_\_  
11. Manner of Death: \_\_\_\_\_  
12. Signature of Medical Examiner: \_\_\_\_\_  
13. Title of Medical Examiner: \_\_\_\_\_  
14. Date of Examination: \_\_\_\_\_  
15. Signature of Coroner: \_\_\_\_\_  
16. Title of Coroner: \_\_\_\_\_  
17. Date of Filing: \_\_\_\_\_  
18. Signature of Registrar: \_\_\_\_\_  
19. Title of Registrar: \_\_\_\_\_  
20. Date of Issuance: \_\_\_\_\_

FOR STATE  
HEALTH OFFICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2665

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>2/22/58</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>506 Bedford Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Rossi</b> Last <b>Rossi</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/7/1872</b>
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>86</b> Days <b>86</b> Hours <b>86</b> Min.	IF UNDER 24 HRS. Hours <b>86</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired - Tailor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	11. BIRTHPLACE (State or foreign country) <b>Italy</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Pasquale Rossi</b>	
14. MOTHER'S MAIDEN NAME <b>Filomena Natale</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>P.O.Box 599</b> Address <b>Cumberland, Md.</b> <b>Allegany County Infirmary Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Chronic Myocarditis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Rt. Hemiplegia</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>2/22/58</b> , 19____, to <b>3/15/58</b> , 19____, that I last saw the deceased alive on <b>3/15/58</b> , 19____, and that death occurred at <b>9:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene Street</b> DATE SIGNED <b>3/17/58</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>3/17/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3/19/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Smith</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2666

## CERTIFICATE OF DEATH

02674

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>24 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BURLINGTON</b> 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.</b>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>ROTRUCK</b> Last <b>ROTRUCK</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>20</b> Year <b>19 58</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 8</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY TUCKER</b>				14. MOTHER'S MAIDEN NAME <b>VICKIE OWENS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Perforation of Esophagus with Empyema</b> 150x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Esophagus Probable.</b> DUE TO (c) <b>? several months.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>22 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2-26</b> , 19 <b>58</b> , to <b>3-19</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-19</b> , 19 <b>58</b> , and that death occurred at <b>4:45</b> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>3-20-58</b>							
ACTUAL SIGNATURE <b>CALVIN HADIDIAN</b> M.D.				PHYSICIAN'S NAME (Type) <b>CALVIN HADIDIAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>23 Mar. 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lahmansville</b>		22d. LOCATION (City, town, or county) (State) <b>Grant Co. W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Allen Rotruck</b> ADDRESS <b>Keyser, W. Va.</b>				24a. REC'D BY REGISTRAR <b>DATE MAR 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>DeLoach</b>	

RECEIVED

MAR 27 1958

BUREAU V. S.

02675

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS. A15ME  
BM 2/57

VS. AISME  
BM 2/57

2668 MED

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Paw Paw</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>James O Santymire</b>		4. DATE OF DEATH Month Day Year <b>March 31 19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 29, 1886</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Hampshire Co., W. Va.</b>	
13. FATHER'S NAME <b>Thomas Santymire</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Allen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-10-8581</b>	
17. INFORMANT <b>Memorial Hospital Records</b>		18. ADDRESS <b>Memorial Hospital Records</b>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured dissecting aneurism of the aorta</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		DATE SIGNED <b>March 31, 1958</b>	
EXAMINER'S NAME (Type) <b>H. V. Deming, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/3/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Woodrow Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hampshire Co., W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm H. Hunter Berkeley Springs W. Va.</b>		24a. REC'D BY REGISTRAR <b>APR 3 '58</b>	
ADDRESS <b>Berkeley Springs W. Va.</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12  
FOR STATE  
HEALTH DEPT.

RECEIVED  
STATE BOARD

BUREAU V. 3

APR 3 1958

RECEIVED



ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02676

2669

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN 1b <b>years 02</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>455 Walnut Street</b>		d. STREET ADDRESS <b>455 Walnut Street</b>	
3. NAME OF DECEASED (Type or print) First <b>RACHEL</b> Middle <b>ELLEN</b> Last <b>SCHULTZ</b>		4. DATE OF DEATH Month <b>March</b> Day <b>27</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 11, 1881</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Salem Humbertson</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Burton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Regina E. Schultz</b>		18. ADDRESS <b>455 Walnut Street, Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>High Blood Pressure</b> DUE TO (c) <b>Chronic Nephrotic Albuminuria</b> INTERVAL BETWEEN ONSET AND DEATH <b>1-5 min</b> <b>5 years</b> <b>5 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>no</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>none</b> 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1, 1940</b> , to <b>March 27, 1958</b> , that I last saw the deceased alive on <b>March 1, 1958</b> , and that death occurred at <b>8 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F. Allan G. Murray</b>		ADDRESS (Street, city or town, state) <b>292 Nat Hwy LaVale Md</b>	
PHYSICIAN'S NAME (Type) <b>F. Allan G. Murray M.D.</b>		DATE SIGNED <b>3/27/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 30, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Luke's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>APR 1 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

BUREAU V. S.

APR 1 1958

RECEIVED

2670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>524 Columbia Ave.</b>				d. STREET ADDRESS <b>524 Columbia Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>Elizabeth</b> Last <b>Screen</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 22, 1886</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Judy</b>				14. MOTHER'S MAIDEN NAME <b>Maria Spatz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>195-30-4240</b>		17. INFORMANT Address <b>Mrs. Eva See, Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAY 17 58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Leach</b>	

# CERTIFICATE OF DEATH

BUREAU Y. 3

MAR 17 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2671

## CERTIFICATE OF DEATH

Reg. Dist. No.

02678

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 1/2 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND,</b> d. STREET ADDRESS <b>179 Green Street.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>KATHERINE</b> Middle <b>SHANNON</b> Last 4. DATE OF DEATH Month <b>MARCH</b> Day <b>26</b> Year <b>1958</b>		5. SEX <b>FEMALE</b> 6. COLOR OR RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>3/20/1882</b> 9. AGE (In years last birthday) yrs. <b>76</b> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PATRICK MURPHY (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH DUANHUE (DECEASED)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>PT'S CHART</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myocarditis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>4 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 1</b> , 19 <b>57</b> , to <b>Mar 26</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Mar 25</b> , 19 <b>58</b> , and that death occurred at <b>2:55 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. W. Trevaskis, Sr.</b> M.D. <b>220 Baltimore Ave</b>		DATE SIGNED <b>3/27/58</b>	
PHYSICIAN'S NAME (Type) <b>RICHARD W. TREVASKIS SR., M.D.</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>3/28/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul Cm.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc</b>		ADDRESS <b>Cumb Md</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James A. Smith</i>		DATE OF DEATH <i>1/15/1958</i>	
PLACE OF DEATH <i>Home</i>		AGE <i>71</i>	
OCCUPATION <i>Retired</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DATE OF BURIAL <i>1/18/1958</i>	
PLACE OF BURIAL <i>St. Mary's Cemetery</i>		NAME OF MINISTER <i>Rev. J. H. Jones</i>	
NAME OF NEXT OF KIN <i>John A. Smith</i>		NAME OF PHYSICIAN <i>Dr. W. H. Brown</i>	
ADDRESS <i>1234 Main St., Baltimore, Md.</i>		SIGNATURE OF DECEASED <i>(Signature)</i>	
SIGNATURE OF NEXT OF KIN <i>(Signature)</i>		SIGNATURE OF PHYSICIAN <i>(Signature)</i>	
DATE OF CERTIFICATE <i>1/15/1958</i>		OFFICIAL USE	

BUREAU V. B.

JAN 28 1958

RECEIVED

James A. Smith (Grand Mr.)  
1/15/58  
1234 Main St. (Grand Mr.)



2704  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		d. STREET ADDRESS <b>73 Spring Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Etta</b> Last <b>Shimer</b>		4. DATE OF DEATH Month <b>March</b> Day <b>28th</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 15th, 1880</b>
9. AGE (In years lost birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own Housework</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lacy W. Ross</b>		14. MOTHER'S MAIDEN NAME <b>Madona Miller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Albert Miller, 73 Spring St., F'bg. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic, Hypertensive, Heart Disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/26</b> , 19 <b>58</b> , to <b>3/28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/28</b> , 19 <b>58</b> , and that death occurred at <b>9:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Martin M. Rothstein</b> M.D. <b>48 BROADWAY</b> PHYSICIAN'S NAME (Type) <b>MARTIN M. ROTHSTEIN M.D. FROSTBURG MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-30-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 31 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

See last page

DEATH

DATE OF DEATH

1938

TIME OF DEATH

10:15 AM

PLACE OF DEATH

HOME

CAUSE OF DEATH

HEART DISEASE

DATE OF BIRTH

1900

PLACE OF BIRTH

INDIANA

DATE OF DEATH

1938

TIME OF DEATH

10:15 AM

PLACE OF DEATH

HOME

CAUSE OF DEATH

HEART DISEASE

DATE OF BIRTH

1900

PLACE OF BIRTH

INDIANA

DATE OF DEATH

1938

TIME OF DEATH

10:15 AM

PLACE OF DEATH

HOME

CAUSE OF DEATH

HEART DISEASE

DATE OF BIRTH

1900

PLACE OF BIRTH

INDIANA

BUREAU V. 2

MAR 31 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2672

## CERTIFICATE OF DEATH

Reg. Dist. No. 02680

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>39 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>319 Springdale Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ira</b> Middle <b>Tarlton</b> Last <b>Shipley</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1893</b>
9. AGE (In years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman</b>	
11. BIRTHPLACE (State or foreign country) <b>Friendsville, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Squire Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Minnie Shroyer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>705-07-6655</b>	
17. INFORMANT <b>Raymond H. Shipley, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Prostate</b> DUE TO (b) <b>7 weeks</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>177x</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 15, 1958</b> to <b>March 14, 1958</b> , that I last saw the deceased alive on <b>March 14, 1958</b> , and that death occurred at <b>4:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>202 Va. Ave. Cumberland, Md.</b> DATE SIGNED <b>3-15-58</b> ACTUAL SIGNATURE <b>F. E. Broadrup, M.D.</b> PHYSICIAN'S NAME (Type) <b>F. E. Broadrup, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-18-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>Mar 17 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. BURK		2. SEX Male		3. AGE 65		4. DATE OF DEATH MAR 17 1958	
5. PLACE OF DEATH Home		6. CAUSE OF DEATH Heart Disease		7. MANNER OF DEATH Natural		8. SIGNATURE OF DECEASED JAMES H. BURK	
9. SIGNATURE OF WITNESSES JAMES H. BURK		10. SIGNATURE OF DECEASED JAMES H. BURK		11. SIGNATURE OF DECEASED JAMES H. BURK		12. SIGNATURE OF DECEASED JAMES H. BURK	
13. SIGNATURE OF DECEASED JAMES H. BURK		14. SIGNATURE OF DECEASED JAMES H. BURK		15. SIGNATURE OF DECEASED JAMES H. BURK		16. SIGNATURE OF DECEASED JAMES H. BURK	
17. SIGNATURE OF DECEASED JAMES H. BURK		18. SIGNATURE OF DECEASED JAMES H. BURK		19. SIGNATURE OF DECEASED JAMES H. BURK		20. SIGNATURE OF DECEASED JAMES H. BURK	
21. SIGNATURE OF DECEASED JAMES H. BURK		22. SIGNATURE OF DECEASED JAMES H. BURK		23. SIGNATURE OF DECEASED JAMES H. BURK		24. SIGNATURE OF DECEASED JAMES H. BURK	
25. SIGNATURE OF DECEASED JAMES H. BURK		26. SIGNATURE OF DECEASED JAMES H. BURK		27. SIGNATURE OF DECEASED JAMES H. BURK		28. SIGNATURE OF DECEASED JAMES H. BURK	
29. SIGNATURE OF DECEASED JAMES H. BURK		30. SIGNATURE OF DECEASED JAMES H. BURK		31. SIGNATURE OF DECEASED JAMES H. BURK		32. SIGNATURE OF DECEASED JAMES H. BURK	
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89. SIGNATURE OF DECEASED JAMES H. BURK		90. SIGNATURE OF DECEASED JAMES H. BURK		91. SIGNATURE OF DECEASED JAMES H. BURK		92. SIGNATURE OF DECEASED JAMES H. BURK	
93. SIGNATURE OF DECEASED JAMES H. BURK		94. SIGNATURE OF DECEASED JAMES H. BURK		95. SIGNATURE OF DECEASED JAMES H. BURK		96. SIGNATURE OF DECEASED JAMES H. BURK	
97. SIGNATURE OF DECEASED JAMES H. BURK		98. SIGNATURE OF DECEASED JAMES H. BURK		99. SIGNATURE OF DECEASED JAMES H. BURK		100. SIGNATURE OF DECEASED JAMES H. BURK	

BURKAU Y. B.

MAR 17 1958

RECEIVED

2673 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN lb <b>2 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
f. STREET ADDRESS <b>400 Decatur St.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Burley</b> Middle <b>Showalter</b> Last <b>March</b>				4. DATE OF DEATH Day <b>3</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6-1914</b>		9. AGE (In years last birthday) <b>43</b> yrs.	IF UNDER 1 YEAR Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min.	IF UNDER 24 HRS. Months <b>43</b> Days <b>43</b> Hours <b>43</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W.Md.R.Ry.</b>		11. BIRTHPLACE (State or foreign country) <b>Jenninerton, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Saul Showalter</b>				14. MOTHER'S MAIDEN NAME <b>Ella Carr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>WW LL 214-07-1927</b>		17. INFORMANT Address <b>Sacred Heart Hospital records.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute fatty liver</b> DUE TO <b>581.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral edema (marked)</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>about 3 days.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March. 3-1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>3-5-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 6 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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APR 6 1958  
BUREAU V. 2

Form with multiple sections for medical examination, including fields for patient information, medical history, and examination findings. The form is oriented horizontally but contains text that is rotated 90 degrees clockwise. The text is mirrored across the page, suggesting a bleed-through from the reverse side. Key sections include:

- Section 1: Patient Information (Name, Address, Age, Sex, Race, Religion, Occupation, Education, Marital Status, Date of Birth, Date of Death, Place of Death, Cause of Death, Manner of Death, Signature of Examiner, Date of Examination, Date of Report, etc.)
- Section 2: Medical History (Present Illness, Past Illness, Family History, Social History, etc.)
- Section 3: Examination Findings (Vital Signs, General Appearance, Head, Neck, Chest, Abdomen, Pelvis, Extremities, etc.)
- Section 4: Laboratory Tests (Blood, Urine, Stool, Sputum, etc.)
- Section 5: Pathology (Organ, Tissue, etc.)
- Section 6: Signature of Examiner (Name, Title, Date, etc.)



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02682

Reg. Dist. No.

FOR STATE  
HEALTH DEPT  
M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <span style="float: right;">2671</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b> c. LENGTH OF STAY IN 1b <b>36 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Sacred Heart Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b> d. STREET ADDRESS <b>1116 Blaul Ave</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>Brooks</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 58</b>		5. SEX <b>male</b> 6. COLOR OR RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>July 15-1898</b>		9. AGE (In years last birthday) <b>59 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician helper</b>			
11. BIRTHPLACE (State or foreign country) <b>Rainsburg, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ervin C. Smith</b>			
14. MOTHER'S MAIDEN NAME <b>Annie Sloan Cobbler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-07-0577</b>			
17. INFORMANT <b>(wife) Violet Smith</b>		Address <b>Cumberland, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Coronary sclerosis with angina syndrome</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>sudden about one week.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rest Lawn Memorial Gardens, Cumberland, Md.</b>			
22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		22e. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		22f. LOCATION (City, town, or county) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>MAR 18 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>		24c. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>		24d. REGISTRAR'S SIGNATURE <b>James F. Scarpelli</b>			

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MAR 18 1959

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1959

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE: [REDACTED]  
TITLE: [REDACTED]

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1959

NAME: [REDACTED]  
AGE: [REDACTED]  
SEX: [REDACTED]  
RACE: [REDACTED]  
DATE OF BIRTH: [REDACTED]  
PLACE OF BIRTH: [REDACTED]  
DATE OF DEATH: [REDACTED]  
PLACE OF DEATH: [REDACTED]  
CAUSE OF DEATH: [REDACTED]  
MANNER OF DEATH: [REDACTED]  
SIGNATURE: [REDACTED]  
TITLE: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02683

Reg. Dist. No.

2675

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>ALLEGANY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>		d. STREET ADDRESS <b>101 HUMBERT STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAURA MAY SMITH</b>						4. DATE OF DEATH Month Day Year <b>MARCH 6 19 58</b>													
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 28, 1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA, Petersburg</b>				12. CITIZEN OF WHAT COUNTRY? <b>U. S. AMERICA</b>									
13. FATHER'S NAME <b>ISSAC CRITES</b>						14. MOTHER'S MAIDEN NAME <b>SUSAN PRATT</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>MEMORIAL HOSPITAL</b>				Address <b>CUMBERLAND, MD.</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac Failure</b> <b>420.1</b> DUE TO <b>Myocardial Infarction, Posterior</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>Generalized arteriosclerosis</b> (b) (c)												INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>2 weeks</b> <b>?</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial asthma, chronic</b>														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <b>28 Feb. 1958</b> to <b>6 Mar. 1958</b> , that I last saw the deceased alive on <b>6 Mar. 1958</b> , and that death occurred at <b>6:35 PM</b> , from the causes and on the date stated above.																			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer, M.D.</b>				ADDRESS (Street, city or town, state) <b>122 S. Oak St. Cumberland, Md.</b>				DATE SIGNED <b>8 Mar. 58</b>											
PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>																			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)											
<b>Burial</b>		<b>Mar 9, 1958</b>		<b>Hellcrest Cemetery</b>				<b>Cumberland Md</b>											
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>														ADDRESS <b>Cumberland Md</b>		24a. RECEIVED BY REGISTRAR DATE <b>MAR 11 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

BUREAU V. S.

MAR 11 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film 227 4-11-58 et

2705

## CERTIFICATE OF DEATH

Reg. Dist. No.

02684

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>20 yrs.</b>				d. STREET ADDRESS <b>29 Broadway</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary W. S. Smith</b>				4. DATE OF DEATH Month Day Year <b>3 30 1958</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>W.</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 21 1932</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Eckhart, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Thomas J. Carter</b>		14. MOTHER'S MAIDEN NAME <b>Dorothy A. Chambers</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>217 28 9125</b>		17. INFORMANT <b>Mrs. Thos. J. Carter, Mt. Savage, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxic Myocarditis</b> DUE TO <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LOBAR PNEUMONIA</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cystis - 7 months</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 days</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/29</b> , 19 <b>58</b> , to <b>3/30</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/30</b> , 19 <b>58</b> , and that death occurred at <b>8 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John C. Devers</b> M.D.				ADDRESS (Street, city or town, state) <b>139 E MAIN Frostburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>John C. Devers</b>				DATE SIGNED <b>4/1/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>4-2-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Michael's Cemetery Frostburg Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harper Funeral Home</b>				24a. REC'D BY REGISTRAR <b>APR 1 1958</b>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH



BUREAU V. 8.

APR 7 1938

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02685

Reg. Dist. No.

**FOR STATE HEALTH DEPT.**

2721

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Allegany</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u>		c. LENGTH OF STAY IN lb <u>7 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Winchester Road</u>				d. STREET ADDRESS <u>Winchester Road</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Samuel</u> Middle <u>Edward</u> Last <u>Snyder</u>				<b>4. DATE OF DEATH</b> Month <u>March</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>March 23, 1871</u>		9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tinner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tin Plate Mill</u>		11. BIRTHPLACE (State or foreign country) <u>Millstone Point, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Samuel Snyder</u>			
14. MOTHER'S MAIDEN NAME <u>Susan McCarty</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>Spanish Am.</u>			
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Lucy Helbig</u> <u>Cresaptown, Md.</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic Heart Disease</u> DUE TO (c) <u>Cerebral Hemorrhage (Apoplexy)</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Gradual</u> <u>Approx. 6 Mo.</u> <u>2 Days</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>H. V. Deming M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. H. V. Deming Md.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>March 26, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 28, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>River View Cemetery</u>			
22d. LOCATION (City, town, or county) <u>Hancock, Md.</u>		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>				ADDRESS <u>Cumberland, Md.</u>			
24a. REC'D BY REGISTRAR <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>					

MEDICAL CERTIFICATION

RECEIVED

MAR 31 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2676

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>5 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>STANGLE</b> Last <b>STANGLE</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 12, 1871</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>87</b> Days <b>87</b>	11. IF UNDER 24 HRS. Hours <b>87</b> Min. <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Karl Benzel</b>		14. MOTHER'S MAIDEN NAME <b>THERESA KREAMER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, D-12 Vertebra</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/12</b> , 19 <b>58</b> , to <b>3/16</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/16</b> , 19 <b>58</b> , and that death occurred at <b>9:17 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Leo H. Ley Jr.</b>		DATE SIGNED <b>3/17/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. LEO H. LEY JR.</b>		ADDRESS (Street, city or town, state) <b>412 N Centre St. Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 19, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>S. S. Peter &amp; Paul Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George,</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

MAR 21 '58

BUREAU V. 3

MAR 21 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2706

CERTIFICATE OF DEATH

Reg. Dist. No.

02687

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>		d. STREET ADDRESS <u>Railroad St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Elizabeth</u> Last <u>Stevenson</u>		4. DATE OF DEATH Month <u>3</u> Day <u>20</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-1-1882</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Midland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Shearer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Goodrich</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Clarence Winebrenner, Dght.</u>		18. ADDRESS <u>176 Md. Ave. Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Dilatation</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio-vascular disease</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>± 9 yrs</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/27</u> , 19 <u>58</u> , to <u>3/20</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/20</u> , 19 <u>58</u> , and that death occurred at <u>11:28</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank T. Harrat</u> M.D. <u>26 W. Main St. Frostburg</u>		DATE SIGNED <u>3/21/58</u>	
PHYSICIAN'S NAME (Type) <u>FRANK T. HARRAT MD</u>		<u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-23-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Frostburg Memorial Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Frostburg Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. H. Mattingly</u>		24a. REC'D BY REGISTRAR <u>Mar 24 58</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>W. E. Schuch</u>			

CERTIFICATE OF DEATH

BUREAU V. 31

MAR 24 1939

RECEIVED



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2722

## CERTIFICATE OF DEATH

Reg. Dist. No.

02688

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McGoole</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McGoole</b>	
		f. STREET ADDRESS <b>/</b>	
		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Susan</b> Last <b>Tasker</b>		4. DATE OF DEATH Month <b>Mar.</b> Day <b>31</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1875</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Simon Copeland</b>		14. MOTHER'S MAIDEN NAME <b>Susan Sharpless</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>Troxell Tasker - Cross, W.Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease.</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Rheumatic Arthritis,</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo</b> <b>10 Yrs</b> <b>80 Yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 5th, 1958</b> , to <b>March 31, 1958</b> , that I last saw the deceased alive on <b>March 30, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Piedmont W Va</b> DATE SIGNED			
ACTUAL SIGNATURE <b>James H Wolverton Sr</b>		M.D. <b>Piedmont W Va</b>	
PHYSICIAN'S NAME (Type) <b>James H Wolverton Sr Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>4/2/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Tasker Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cross W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Boul</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>APR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

2732

1. NAME OF DECEASED <b>JOHN J. SMITH</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>	
4. DATE OF DEATH <b>APR 10 1958</b>		5. TIME OF DEATH <b>10:30 AM</b>		6. PLACE OF DEATH <b>HOME</b>	
7. CITY OR TOWN <b>BALTIMORE</b>		8. COUNTY <b>JOHNS HOPKINS</b>		9. STATE <b>MARYLAND</b>	
10. OCCUPATION <b>DRUGGIST</b>		11. CAUSE OF DEATH <b>HEART DISEASE</b>		12. MANNER OF DEATH <b>NATURAL</b>	
13. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		14. SIGNATURE OF WITNESS <b>JOHN J. SMITH</b>		15. SIGNATURE OF PHYSICIAN <b>JOHN J. SMITH</b>	
16. SIGNATURE OF CLERK <b>JOHN J. SMITH</b>		17. SIGNATURE OF REGISTRAR <b>JOHN J. SMITH</b>		18. SIGNATURE OF JUDGE <b>JOHN J. SMITH</b>	
19. SIGNATURE OF SHERIFF <b>JOHN J. SMITH</b>		20. SIGNATURE OF CORONER <b>JOHN J. SMITH</b>		21. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
22. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		23. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		24. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
25. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		26. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		27. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
28. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		29. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		30. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
31. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		32. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		33. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
34. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		35. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		36. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
37. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		38. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		39. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
40. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		41. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		42. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
43. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		44. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		45. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
46. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		47. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		48. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
49. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		50. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		51. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
52. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		53. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		54. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
55. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		56. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		57. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
58. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		59. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		60. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
61. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		62. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		63. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
64. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		65. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		66. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
67. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		68. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		69. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
70. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		71. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		72. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
73. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		74. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		75. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
76. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		77. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		78. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
79. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		80. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		81. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
82. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		83. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		84. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
85. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		86. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		87. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
88. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		89. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		90. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
91. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		92. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		93. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
94. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		95. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		96. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
97. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		98. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		99. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	
100. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		101. SIGNATURE OF JURY <b>JOHN J. SMITH</b>		102. SIGNATURE OF JURY <b>JOHN J. SMITH</b>	

**RECEIVED**  
APR 7 1958  
**BUREAU V. 2**

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disl. No.

FOR STATE  
HEALTH DEPT.

2677

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>66 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10 Independence St.</b>				d. STREET ADDRESS <b>10 Independence St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Lottie May</b> Middle <b>Thomas</b> Last <b>Thomas</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Dec. 23-1891</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b>		IF UNDER 24 HRS. Hours <b>66</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Charles Rice</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Dellinger</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>219 03 9098</b>			
17. INFORMANT <b>(son) Donald Thomas, Cumberland, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO <b>Arteriosclerosis with hypertention</b> Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis with hypertention</b> (a), stating the underlying cause last. DUE TO (c) <b>Arteriosclerosis with hypertention</b> INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>about 3 years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis with hypertention</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H. V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H. V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 15-1958</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/18/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE MAR 19 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

MEDICAL CERTIFICATION

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BUREAU V. B.

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RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02690

2723

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale</b>		c. LENGTH OF STAY IN 1b <b>years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3 North Woodlawn Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle <b>Torkington</b> Last <b>March</b>		4. DATE OF DEATH Month <b>22</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1871</b>
9. AGE (In years last birthday) <b>86</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>8</b> Days <b>22</b> Hours <b>0</b> Min. <b>0</b>	
11. BIRTHPLACE (State or foreign country) <b>Pendleton, Manchester England.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Whittaker</b>		14. MOTHER'S MAIDEN NAME <b>Alice Cooper</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>William Torkington</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Renal Failure</b> DUE TO <b>Diabetes Endarteritis Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Endarteritis Sclerosis</b> (c) <b>Diabetes Endarteritis Sclerosis</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1957</b> to <b>March 1958</b> , that I last saw the deceased alive on <b>March 21</b> 19 <b>58</b> , and that death occurred at <b>2300</b> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S E Enfield</b>		DATE SIGNED <b>March 31 1958</b>	
PHYSICIAN'S NAME (Type) <b>Samuel Enfield M.D. Rt. 1, Mt. Savage, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar 24, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. George Epis. Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 26 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>			

# CERTIFICATE OF DEATH

State of Maryland

County of \_\_\_\_\_

City of \_\_\_\_\_

Age \_\_\_\_\_

Sex \_\_\_\_\_

Color \_\_\_\_\_

Married \_\_\_\_\_

Single \_\_\_\_\_

Widow \_\_\_\_\_

Divorced \_\_\_\_\_

Never married \_\_\_\_\_

Married \_\_\_\_\_

Single \_\_\_\_\_

Widow \_\_\_\_\_

Divorced \_\_\_\_\_

BUREAU W. 11

MAR 26 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 2678 CERTIFICATE OF DEATH

02691

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Allegheny</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>3 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>711 National Highway</b>				e. STREET ADDRESS <b>120 Ruskin Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>ALICE</b> Middle <b>KARY</b> Last <b>TOSH</b>				4. DATE OF DEATH Month <b>March</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 10, 1883</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Somerset Co., Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry C. Beam</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Baldwin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT <b>Albert Tosh, Cumberland, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary left heart</b> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12 July, 1957</b> , to <b>14 March, 1958</b> , that I last saw the deceased alive on <b>12 March, 1958</b> , and that death occurred at <b>12 A. M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.				DATE SIGNED <b>March 14, 1958</b>			
PHYSICIAN'S NAME (Type) <b>W. Alfred Van Ormer</b> <b>122 South Centre Street, Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 17, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ligonier Valley Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Ligonier, Pennsylvania</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. RECEIVED BY REGISTRAR <b>March 17, 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

REGISTERED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2724

CERTIFICATE OF DEATH

Reg. Dist. No. 02692

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Beachwood Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>C.</b> Last <b>Trenum</b>				4. DATE OF DEATH Month <b>March</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 9, 1911</b>	9. AGE (In years last birthday) <b>46</b> yrs.	IF UNDER 1 YEAR: Months <b>4</b> Days <b>4</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Pulp Mill</b>		11. BIRTHPLACE (State or foreign country) <b>Franklyn, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James B. Trenum</b>				14. MOTHER'S MAIDEN NAME <b>Bertha Riggleman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. James C. Trenum</b> Address <b>Lonaconing, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary hemorrhage</b> DUE TO <b>Bronchogenic carcinoma left</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>six months</b> DUE TO <b>lung cancer</b> (c) <b>lung cancer</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Wife</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/12</b> , 19 <b>57</b> , to <b>3/4</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/3</b> , 19 <b>58</b> , and that death occurred at <b>5:00 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>Paul R. Kaul</b> M.D.				PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/6/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b> ADDRESS <b>Lonaconing, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 10 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MAR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2679

## CERTIFICATE OF DEATH

Reg. Dist. No.

02693

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>PENNSYLVANIA</b> b. COUNTY <b>BEDFORD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BEDFORD</b> <b>75X-3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>RT. #3</b>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>L.</b> Last <b>TROUTMAN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>29</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 25, 1882</b>
9. AGE (In years last birthday) <b>75</b>		10. IF UNDER 1 YEAR Months <b>15</b> Days <b>15</b> Hours <b>15</b> Min. <b>15</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMING</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK TROUTMAN</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN ROBINETTE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218-30-7462</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sublethal Hemorrhage</b> DUE TO <b>Coronary Stenosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) <b>?</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/22, 1958</b> to <b>3/28, 1958</b> , that I last saw the deceased alive on <b>3/28, 1958</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>12/1/58</b> ACTUAL SIGNATURE <b>George M. Simons</b> M.D. PHYSICIAN'S NAME (Type) <b>DR. GEORGE M. SIMONS</b> 22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>Mar. 31, 1958</b> 22c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b> 22d. LOCATION (City, town, or county) (State) <b>RFD 3, Bedford, Pa.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		24a. REC'D BY REGISTRAR <b>APR 2 '58</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Smith</b>	

RECEIVED

APR 2 1958

BUREAU V. 3



2725

## CERTIFICATE OF DEATH

02694

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Dawson, Md.</b>		c. LENGTH OF STAY IN 1b <b>50 years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Dawson, Md.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. 3 Keyser, W. Va.</b>			d. STREET ADDRESS <b>R.F.D. 3 Keyser, W. Va.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Laura</b> Middle <b>Virginia</b> Last <b>Van Pelt</b>			4. DATE OF DEATH Month <b>March</b> Day <b>29</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 13, 1874</b>		9. AGE (In years last birthday) yrs. <b>83</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			13. FATHER'S NAME <b>George Lynch</b>		
14. MOTHER'S MAIDEN NAME <b>Caroline Malcolm</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Gilbert Van Pelt R.F.D. 3 Keyser, W. Va.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>July 19 55</b> to <b>March 24 19 58</b> , that I last saw the deceased alive on <b>March 24 19 58</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Paul Healy</b> M.D.			ADDRESS (Street, city or town, state) <b>March 31, 1958</b>		
PHYSICIAN'S NAME (Type) <b>Paul T. Healy, M. D.</b>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>31 Mar. 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dawson Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Allegany Co. Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Allen Rotenbach</b>			ADDRESS <b>Keyser, W. Va.</b>		
24a. REC'D BY REGISTRAR DATE <b>APR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Leach</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2680

## CERTIFICATE OF DEATH

Reg. Dist. No.

02695

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>186 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL &amp; WARWICK AVES</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>VOGTMAN</b> Last <b>VOGTMAN</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26 1875</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>ECKHART, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THEODORE MORGAN</b>		14. MOTHER'S MAIDEN NAME <b>Ann Bird</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Howard Vogtman, 3700 Lincoln Ave.</b>		Address <b>Detroit, Mich.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac failure</b> 443X DUE TO <b>arteriosclerotic and hypertensive cardio-vascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>3 months</b> DUE TO (c) <b>3 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral thrombosis with left hemiplegia 15 Sept 58</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>13 Sept 1957</b> to <b>18 Nov 1958</b> , that I last saw the deceased alive on <b>18 Nov 1958</b> , and that death occurred at <b>7:40 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D.		ADDRESS (Street, city or town, state) <b>122 S. Centre St</b> DATE SIGNED <b>18 Nov 58</b>	
PHYSICIAN'S NAME (Type) <b>W. A. VAN ORMER</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
<b>Burial</b>		<b>3-20-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Frostburg Memorial Pl.</b>		<b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hayer's Funeral Home</b>		ADDRESS <b>Frostburg</b>	
24a. REC'D BY REGISTRAR <b>MAR 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Beach</b>	

MAR 24 1955

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2681

CERTIFICATE OF DEATH

Reg. Dist. No.

02696

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>10 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>310 Waverly Terrace</b>				d. STREET ADDRESS <b>310 Waverly Terrace</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Everett</b> Last <b>Weller</b>				4. DATE OF DEATH Month <b>March</b> Day <b>15</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 13-1905</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artificial silk worker- Celanese</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Md</b>		11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Joseph Weller</b>				14. MOTHER'S MAIDEN NAME <b>Laura Wertz</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-10-8865</b>		17. INFORMANT <b>Mrs. Mary Aaron Ridgley, W. Va</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Cholelithiasis</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE _____ M.D. _____ PHYSICIAN'S NAME (Type) <b>R. W. TREVASKISS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hyndman Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyndman Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>				24a. REC'D BY REGISTRAR <b>MA 1-8-58</b>		24b. REGISTRAR'S SIGNATURE <b>Qu. L. Smith</b>	

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
DATE OF BIRTH		DATE OF DEATH	
JAN 10 1890		JAN 10 1900	
AGE		AGE	
10 YEARS		10 YEARS	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
OCCUPATION		OCCUPATION	
STUDENT		STUDENT	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1900		JAN 10 1900	
LOCAL HEALTH OFFICER		LOCAL HEALTH OFFICER	
J. H. HARRIS		J. H. HARRIS	
DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1900		JAN 10 1900	

BUREAU V. S.

MAR 18 1900

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02697

Reg. Dist. No.

2682

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN lb <b>4 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>D.O.A. Memorial Hospital</b>				d. STREET ADDRESS <b>108 Spruce St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leslie</b> Middle <b>Carl</b> Last <b>Welsh</b>				4. DATE OF DEATH Month <b>March</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 29-1917</b>		9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months <b>41</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O R.Ry.</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emanuel Welsh</b>				14. MOTHER'S MAIDEN NAME <b>Mable Troutman</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>W.W.2</b>		17. INFORMANT <b>wife-Mrs.L.C.Welsh</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>?</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>?</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b>19</b> a. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 24-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 28 1933

BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: \_\_\_\_\_  
AGE: \_\_\_\_\_  
SEX: \_\_\_\_\_  
RACE: \_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_  
PLACE OF BIRTH: \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_  
CAUSE OF DEATH: \_\_\_\_\_  
MANNER OF DEATH: \_\_\_\_\_  
SIGNATURE OF EXAMINER: \_\_\_\_\_  
DATE: \_\_\_\_\_

FOR STATE  
HEALTH DEPT.

RECEIVED

2683

## CERTIFICATE OF DEATH

02698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL ***OLDTOWN</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>Route 1, Oldtown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>JESS EDWARD WHORTON</b>				4. DATE OF DEATH Month Day Year <b>MARCH 8 19 58</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/05</b>		9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND Little Orleans</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE WHORTON (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>IDA HILL WHORTON (DECEASED)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>PT'S CHART</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>330x DUBERACHNOID HEMORRHAGE</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/1</b> , 19 <b>58</b> , to <b>3/8</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3/7</b> , 19 <b>58</b> , and that death occurred at <b>12:00AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>456 N. CENTRE ST., CUMBERLAND, MD.</b> DATE SIGNED <b>3/8/58</b>							
ACTUAL SIGNATURE <b>Leo H. Levy Jr</b> M.D.							
PHYSICIAN'S NAME (Type) <b>LEO H. LEVY, M.D.</b>				<b>456 N. CENTRE ST., CUMBERLAND, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>March 10 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Glendale Church Cemtery Flintstone, Maryland</b>		22d. LOCATION (City, town, or county) (State) <b>Flintstone, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 11 58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John J. [illegible]</i>		2. SEX <i>Male</i>		3. AGE <i>68</i>	
4. DATE OF DEATH <i>March 11, 1950</i>		5. TIME OF DEATH <i>10:15 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>[illegible]</i>	
10. OCCUPATION <i>[illegible]</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>[illegible]</i>	
13. PREVIOUS ILLNESS <i>[illegible]</i>		14. MEDICAL HISTORY <i>[illegible]</i>		15. SIGNATURE OF PHYSICIAN <i>[illegible]</i>	
16. SIGNATURE OF REGISTRAR <i>[illegible]</i>		17. SIGNATURE OF WITNESSES <i>[illegible]</i>		18. SIGNATURE OF DECEASED <i>[illegible]</i>	

**RECEIVED**  
MAR 11 1950  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DR. BALLIN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02699

2684

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X CUMBERLAND</b>		d. STREET ADDRESS <b>RT. #2, BALTIMORE PIKE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ARTHUR WOODROW WILLISON</b>		4. DATE OF DEATH Month Day Year <b>MARCH XME 24 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 10, 1912</b>
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OIL DISTRIBUTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLISON, NORVAL</b>		14. MOTHER'S MAIDEN NAME <b>PERRIN, JUDY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 11 214-05-6341</b>	
17. INFORMANT <b>Mrs. Marguerite Willison</b>		Address <b>St. 2 Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism</b> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe emphysema, cor pulmonale</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-23</b> , 19 <b>56</b> , to <b>3-23</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>3-23</b> , 19 <b>58</b> , and that death occurred at <b>12:45 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>62 Greene St. Cumberland, Md.</b> DATE SIGNED <b>3-24-58</b>			
ACTUAL SIGNATURE <b>Regis W. Ballin</b>		M.D. <b>62 Greene St. Cumberland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. BALLIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 26, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <b>MAR 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Leach</b>	

# CERTIFICATE OF DEATH

BUREAU V. S.

MAR 27 1958

RECEIVED



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02700

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>313 Fredrick St.</b>				d. STREET ADDRESS <b>313 Fredrick St/</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Marcellus</b> Middle <b>George</b> Last <b>Wilson</b>				4. DATE OF DEATH Month <b>March</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 6-1869</b>	
9. AGE (In years and birthday) <b>88 yrs.</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired-bartender- Queen City Hotel</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland, Md.</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Clem Wilson</b>				14. MOTHER'S MAIDEN NAME <b>Marie Atkinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-12-8273</b>		17. INFORMANT Address <b>(son) M.G. Wilson Jr. Cumberland, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular-renal disease</b> <b>442X</b> DUE TO <b>Arteriosclerosis with hypertention</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>about 3 years</b> (c) <b>about 6 years.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERNAL BETWEEN</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <b>March 15-1958</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar. 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sumner Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. Hafer</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 17 1958

BUREAU V. 2

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE OF EXAMINATION: [illegible]

FOR STATE  
HEALTH DEPT.

40 YEARS IN THE SERVICE OF THE STATE

2707

CERTIFICATE OF DEATH

Reg. Dist. No. 02701

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>			c. LENGTH OF STAY IN 1b <b>2 wks.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>22 Frostburg</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>				d. STREET ADDRESS <b>92 Linden St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Marguerite (Cook) Wilson</b>				4. DATE OF DEATH Month Day Year <b>March 21, 19 58</b>			
5. SEX <b>female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 24, 1902</b>	
9. AGE (In years last birthday) <b>55 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired teacher</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry F. Cook</b>				14. MOTHER'S MAIDEN NAME <b>Jane Barr</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>212-24-0037</b>		17. INFORMANT <b>Madeline Cook, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac dilatation</b> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocarditis</b> DUE TO (c) <b>Rheumatic Heart Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>14 mos.</b> <b>42 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Worry.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/11, 1947</b> , to <b>3/20, 1958</b> , that I last saw the deceased alive on <b>12/21, 1958</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Frank T. Harbat</b> M.D.				ADDRESS (Street, city or town, state) <b>26 W. Mechanic St Frostburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>FRANK T. HARBAT MD.</b>				DATE SIGNED <b>3/24/58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-23-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 24 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Chas. Smith</b>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAR 24 1959

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2708

## CERTIFICATE OF DEATH

02702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>Life time</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Mary Holsinger Winebrenner</b>		4. DATE OF DEATH Month Day Year <b>3 17 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 28 1902</b>
9. AGE (In years last birthday) <b>55 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13. FATHER'S NAME <b>Patrick B. Byrnes</b>		14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Grimes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Anne Robinson (Sister) Contonniel Ext.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic</b> <b>260X</b> DUE TO <b>Diabetic Heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19 58</b>		22. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>134 E MAIN</b>		24. (City or town) (County) (State) <b>Frostburg, Md.</b>	
25. I certify that I attended the deceased from <b>March 16, 1958</b> , to <b>March 17, 1958</b> , that I last saw the deceased alive on <b>March 16, 1958</b> , and that death occurred at <b>2 AM</b> , from the causes and on the date stated above.		26. ADDRESS (Street, city or town, state) <b>134 E MAIN</b>	
27. ACTUAL SIGNATURE <b>John C Devers</b> M.D.		28. DATE SIGNED <b>3/18</b>	
29. PHYSICIAN'S NAME (Type) <b>John C Devers</b>		30. ADDRESS <b>Frostburg, Md.</b>	
31. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		32. DATE THEREOF <b>3-19-58</b>	
33. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		34. LOCATION (City, town, or county) (State) <b>Eckhart Md.</b>	
35. FUNERAL DIRECTOR'S SIGNATURE <b>O. H. Mattingly</b> ADDRESS <b>Frostburg, Md.</b>		36. REC'D BY REGISTRAR <b>W. Leach</b> DATE <b>MAR 21 1958</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. OCCUPATION		9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02703

2686

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>St. Brook's Hotel, Baltimore Ave &amp; Front</b>				d. STREET ADDRESS <b>Brook's Hotel</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>B.</b> Last <b>Wright</b>				4. DATE OF DEATH Month <b>March</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>61 M</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 30-1896</b>		9. AGE (In years last birthday) <b>61 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B&amp;O.R.Ry.</b>		11. BIRTHPLACE (State or foreign country) <b>West Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>705-05-5181</b>		17. INFORMANT Address <b>B&amp;O record &amp; card in pocket</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>Coronary sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>  <b>?</b>  <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>H.V. Deming M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>H.V. Deming M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>March 14-1958</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-19-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>MAR 18 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert Smith</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.



RECEIVED  
MAR 18 1958  
BUREAU Y. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2687

## CERTIFICATE OF DEATH

02704

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>John Kilburn Yost</b>		4. DATE OF DEATH Month Day Year <b>March 18, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10, 1880</b>
9. AGE (In years lost birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mach.</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
13. FATHER'S NAME <b>Peter E. Yost</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Catherine See</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>William R. Yost</b>	
17. INFORMANT <b>William R. Yost</b>		Address <b>Cumberland, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PULMONARY EDEMA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>MYOCARDIAL INFARCTION</b> DUE TO (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b> <b>4-5 HRS</b> <b>7</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>MAR 18, 1958</b> , to <b>MARCH 18, 1958</b> , that I lost sows the deceased olive on <b>MARCH 18, 1958</b> , and that death occurred at <b>7:15 P.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>441 N. CENTRE ST</b> DATE SIGNED <b>3.20.58</b>			
ACTUAL SIGNATURE <b>William P. James</b> M.D.		M.D. <b>441 N. CENTRE ST</b>	
PHYSICIAN'S NAME (Type) <b>William P. James</b>		<b>441 North Centre St. Cumberland, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Mar 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>John J. Hafer</b>			

CERTIFICATE OF DEATH



1. NAME OF DECEASED JAMES ALFRED JONES		2. SEX Male	
3. AGE 37		4. DATE OF BIRTH 10.10.1920	
5. PLACE OF BIRTH Baltimore, Maryland		6. OCCUPATION None	
7. MARITAL STATUS Single		8. CAUSE OF DEATH Heart Disease	
9. PLACE OF DEATH Baltimore, Maryland		10. DATE OF DEATH 10.10.1957	
11. SIGNATURE OF PHYSICIAN J. ALFRED JONES		12. SIGNATURE OF REGISTRAR J. ALFRED JONES	
13. SIGNATURE OF WITNESSES J. ALFRED JONES		14. SIGNATURE OF DECEASED J. ALFRED JONES	
15. SIGNATURE OF DECEASED J. ALFRED JONES		16. SIGNATURE OF DECEASED J. ALFRED JONES	
17. SIGNATURE OF DECEASED J. ALFRED JONES		18. SIGNATURE OF DECEASED J. ALFRED JONES	
19. SIGNATURE OF DECEASED J. ALFRED JONES		20. SIGNATURE OF DECEASED J. ALFRED JONES	
21. SIGNATURE OF DECEASED J. ALFRED JONES		22. SIGNATURE OF DECEASED J. ALFRED JONES	
23. SIGNATURE OF DECEASED J. ALFRED JONES		24. SIGNATURE OF DECEASED J. ALFRED JONES	
25. SIGNATURE OF DECEASED J. ALFRED JONES		26. SIGNATURE OF DECEASED J. ALFRED JONES	
27. SIGNATURE OF DECEASED J. ALFRED JONES		28. SIGNATURE OF DECEASED J. ALFRED JONES	
29. SIGNATURE OF DECEASED J. ALFRED JONES		30. SIGNATURE OF DECEASED J. ALFRED JONES	
31. SIGNATURE OF DECEASED J. ALFRED JONES		32. SIGNATURE OF DECEASED J. ALFRED JONES	
33. SIGNATURE OF DECEASED J. ALFRED JONES		34. SIGNATURE OF DECEASED J. ALFRED JONES	
35. SIGNATURE OF DECEASED J. ALFRED JONES		36. SIGNATURE OF DECEASED J. ALFRED JONES	
37. SIGNATURE OF DECEASED J. ALFRED JONES		38. SIGNATURE OF DECEASED J. ALFRED JONES	
39. SIGNATURE OF DECEASED J. ALFRED JONES		40. SIGNATURE OF DECEASED J. ALFRED JONES	
41. SIGNATURE OF DECEASED J. ALFRED JONES		42. SIGNATURE OF DECEASED J. ALFRED JONES	
43. SIGNATURE OF DECEASED J. ALFRED JONES		44. SIGNATURE OF DECEASED J. ALFRED JONES	
45. SIGNATURE OF DECEASED J. ALFRED JONES		46. SIGNATURE OF DECEASED J. ALFRED JONES	
47. SIGNATURE OF DECEASED J. ALFRED JONES		48. SIGNATURE OF DECEASED J. ALFRED JONES	
49. SIGNATURE OF DECEASED J. ALFRED JONES		50. SIGNATURE OF DECEASED J. ALFRED JONES	
51. SIGNATURE OF DECEASED J. ALFRED JONES		52. SIGNATURE OF DECEASED J. ALFRED JONES	
53. SIGNATURE OF DECEASED J. ALFRED JONES		54. SIGNATURE OF DECEASED J. ALFRED JONES	
55. SIGNATURE OF DECEASED J. ALFRED JONES		56. SIGNATURE OF DECEASED J. ALFRED JONES	
57. SIGNATURE OF DECEASED J. ALFRED JONES		58. SIGNATURE OF DECEASED J. ALFRED JONES	
59. SIGNATURE OF DECEASED J. ALFRED JONES		60. SIGNATURE OF DECEASED J. ALFRED JONES	
61. SIGNATURE OF DECEASED J. ALFRED JONES		62. SIGNATURE OF DECEASED J. ALFRED JONES	
63. SIGNATURE OF DECEASED J. ALFRED JONES		64. SIGNATURE OF DECEASED J. ALFRED JONES	
65. SIGNATURE OF DECEASED J. ALFRED JONES		66. SIGNATURE OF DECEASED J. ALFRED JONES	
67. SIGNATURE OF DECEASED J. ALFRED JONES		68. SIGNATURE OF DECEASED J. ALFRED JONES	
69. SIGNATURE OF DECEASED J. ALFRED JONES		70. SIGNATURE OF DECEASED J. ALFRED JONES	
71. SIGNATURE OF DECEASED J. ALFRED JONES		72. SIGNATURE OF DECEASED J. ALFRED JONES	
73. SIGNATURE OF DECEASED J. ALFRED JONES		74. SIGNATURE OF DECEASED J. ALFRED JONES	
75. SIGNATURE OF DECEASED J. ALFRED JONES		76. SIGNATURE OF DECEASED J. ALFRED JONES	
77. SIGNATURE OF DECEASED J. ALFRED JONES		78. SIGNATURE OF DECEASED J. ALFRED JONES	
79. SIGNATURE OF DECEASED J. ALFRED JONES		80. SIGNATURE OF DECEASED J. ALFRED JONES	
81. SIGNATURE OF DECEASED J. ALFRED JONES		82. SIGNATURE OF DECEASED J. ALFRED JONES	
83. SIGNATURE OF DECEASED J. ALFRED JONES		84. SIGNATURE OF DECEASED J. ALFRED JONES	
85. SIGNATURE OF DECEASED J. ALFRED JONES		86. SIGNATURE OF DECEASED J. ALFRED JONES	
87. SIGNATURE OF DECEASED J. ALFRED JONES		88. SIGNATURE OF DECEASED J. ALFRED JONES	
89. SIGNATURE OF DECEASED J. ALFRED JONES		90. SIGNATURE OF DECEASED J. ALFRED JONES	
91. SIGNATURE OF DECEASED J. ALFRED JONES		92. SIGNATURE OF DECEASED J. ALFRED JONES	
93. SIGNATURE OF DECEASED J. ALFRED JONES		94. SIGNATURE OF DECEASED J. ALFRED JONES	
95. SIGNATURE OF DECEASED J. ALFRED JONES		96. SIGNATURE OF DECEASED J. ALFRED JONES	
97. SIGNATURE OF DECEASED J. ALFRED JONES		98. SIGNATURE OF DECEASED J. ALFRED JONES	
99. SIGNATURE OF DECEASED J. ALFRED JONES		100. SIGNATURE OF DECEASED J. ALFRED JONES	

BUREAU V. S.

MAR 24 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2688

## CERTIFICATE OF DEATH

02705

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. STREET ADDRESS <b>30 VIRG INIA AVE.,</b>	
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>W.</b> Last <b>YOUNG</b>		4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>19 58.</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 13, 1891</b>
9. AGE (In years last birthday) <b>67 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate Agent</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11c. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JAMES R. YOUNG</b>		14. MOTHER'S MAIDEN NAME <b>ANNA FISHER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>212-32-8367</b>	
17. INFORMANT <b>War I</b>		Address <b>MEMORIAL HOSPITAL * CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertension</b> <b>443X</b> DUE TO <b>Cardiac Hypertrophy &amp; Distention</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Pulmonary Edema - Pneumonia</b> DUE TO <b>5 days</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>6 min.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 23, 1958</b> to <b>Jan. 24, 1958</b> , that I last saw the deceased alive on <b>Jan. 24, 1958</b> , and that death occurred at <b>6:15 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clay C. Durrett</b>		DATE SIGNED <b>3/26/58</b>	
PHYSICIAN'S NAME (Type) <b>DR. CLAY DURRETT</b>		ADDRESS (Street, city or town, state) <b>236 24th Ave. Cumberland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-27-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>MAR 28 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2709

## CERTIFICATE OF DEATH

Reg. Dist. No.

02706

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>10 hrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>YUTZY</b> Last <b>YUTZY</b>		4. DATE OF DEATH Month <b>March</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-20-1894</b>
9. AGE (In years last birthday) <b>64 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>11x-2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gunter Hotel</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Baker</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Bittner</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-26-7602</b>	
17. INFORMANT <b>Elmer Yutzy, Rt. 2, Frostburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b>Several years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>Several years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 8, 1958</b> to <b>Mar 9, 1958</b> , that I last saw the deceased alive on <b>Mar 8, 1958</b> , and that death occurred at <b>9:00 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <b>E. Main St., Frostburg, Md. Mar 10 1958</b>	
ACTUAL SIGNATURE <b>W. O. McLane M.D.</b>		PHYSICIAN'S NAME (Type) <b>W. O. McLane, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-11-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pocohontas Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocohontas, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. R. Durst, Frostburg, Md.</b>		ADDRESS <b>24a. REC'D BY REGISTRAR</b> <b>DATE MAR 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. O. McLane</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE

BUREAU V. 2

MAR 18 1959

RECEIVED